Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING

Formal meeting, to which members of the public are invited to observe. Please note that questions from members of the public should be asked at the end of the meeting, and relate to one of the agenda items

10.30am – c.1pm WEDNESDAY 29TH APRIL 2015

THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

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4-24	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal	-

Date of next meetings:

- 27th May 2015, 10.30am, Academic Centre, Maidstone Hospital
- 24th June 2015, 10.30am, Academic Centre, Maidstone Hospital
- 22nd July 2015, 10.30am, Education Centre, Tunbridge Wells Hospital

Anthony Jones,
Chairman

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 25TH MARCH 2015, 10.30 A.M. AT TUNBRIDGE WELLS HOSPITAL

DRAFT, FOR APPROVAL

Present:	Kevin Tallett	Non-Executive Director (Chair)	(KT)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Steve Tinton	Non-Executive Director	(ST)
In attendance:	Jonathan Appleby	Clinical Director, Surgery (item 3-8 only)	(JA)
	Paul Bentley	Director of Workforce and Communications	(PB)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Annemieke Koper	Staff Side representative	(AKo)
	Darren Yates	Head of Communications (apart from item 3-8)	(DY)

3-1 To receive apologies for absence

Apologies were received from Anthony Jones (AJ), Chairman of the Trust Board; and Alex King (AK), Non-Executive Director. It was also noted that Stephen Smith (SS), Associate Non-Executive Director would not be in attendance.

3-2 To declare interests relevant to agenda items

There were no declarations of interest.

3-3 Minutes of the Part 1 meeting of 25th February 2015

KT referred to the circulated document, and highlighted that the minute of item 2-10 had been agreed with the patient that had attended the meeting to relay their experiences at the Trust.

The minutes were agreed as a true and accurate record of the meeting subject to the following amendment:

- Item 2-7, page 3: Replace "KT stated that he believed the Trust's plan worked, but only marginally…" with "KT stated that he believed the Trust's plan worked, but only at the margins…"

Action: Amend the minutes of the Part 1 meeting of 25th February 2015 (Trust Secretary, March 2015)

3-4 To note progress with previous actions

The circulated report was noted. The following actions were discussed in detail:

- **Items 2-11 ("Seek the views of other organisations in relation to the management (including procurement) of medical devices" and "Submit a report to a future Trust Board meeting containing the conclusions arising from the liaison with other organisations in relation to the management of medical devices"):** PS reported that he had discussed the issue via a Medical Directors' network on 19/03/15 and a report would be submitted to the Trust Board in April 2015.

- **Item 2-13 ("Submit a report to the next Audit and Governance Committee responding to the concerns arising from the latest Internal Audit review of Consultant Job Planning"):** It was noted that PS would be attending the Audit and Governance Committee on 6th May 2015 to discuss the concerns.

3-5 Chairman's report

KT reported that the Non-Executive Directors had met earlier that day, and agreed three key issues they would like the Trust Board to discuss in the future. KT continued that the issues were: Management of capacity; Career opportunities for Nurses; and the creation of a 'high performing' culture. KT added that he would leave AJ and GD to consider how each of these should be discussed.

GD acknowledged the need to discuss such issues, and noted that time needed to be created to enable open discussion, in a Board Forum-type meeting.

3-6 Chief Executive's report

GD referred to the circulated report and highlighted the following points:
- The Care Quality Commission (CQC) inspection report provided an opportunity to introduce positive change
- Jim Lusby would be joining the Trust as Deputy Chief Executive at the end of April
- The next phase of the redevelopment of Maidstone Hospital was being implemented

3-7 Integrated Performance Report for Feb 2015 (incorporating an update on recruitment & retention)

GD referred to the circulated report and invited his Executive Director colleagues to speak. AG then highlighted the following points:
- Non-elective activity remained a key issue. Attendances were similar to the previous year, but there had been an increase in patients' age and acuity, which had resulted in a longer Length of Stay (LoS) for admitted patients, as well as more Delayed Transfers of Care.
- Activity with a zero-day length of stay had reduced dramatically, via the initiatives that had been introduced in A&E. The LoS of patients staying 5 days or less had also reduced
- Elderly frail patients, and those that needed to be placed in care were therefore the key issue
- These issues were adversely affecting the ability to meet the A&E 4-hour waiting time target

KT asked whether there was collective commitment to solve the challenges. AG replied that although there had been commitment, restrictions relating to complex discharges remained, which included the availability of packages of care, and community capacity. AG noted that Social Services were considering placing patients 'out of area'.

SD highlighted the potential adverse impact on individuals who were placed 'out of area'. AG acknowledged the point, but noted that the options were limited, given the lack of Care capacity in West Kent.

GD remarked that the metrics that were monitored indicated that A&E was working well, as were the joint initiatives with the Clinical Commissioning Group (CCG) and Kent Community Healthcare NHS Foundation Trust, but none of the initiatives had benefitted elderly frail patients, and this cohort therefore needed to be the focus of further attention.

GD then acknowledged SD's earlier concern regarding 'out of area' placements, and noted that such decisions were not taken lightly, but asserted that without such placements, the hospital's ability to function as an acute hospital was under threat.

AG then continued, and reported that there had been a 12-hour trolley breach in A&E. AG stated that Root Cause Analysis had showed that the breach was related to communication issues, and had resulted in learning for the operations and clinical teams. AG added that some immediate changes had been implemented to prevent recurrence, and the roles and responsibilities of all those involved had been re-launched.

KT asked whether the communication systems to which AG referred were manual. AG replied that there was an A&E IT tracking system in place, but clarified that the communication problems related to human performance. KT emphasised that focusing on human performance would be a useful focus for the aforementioned discussions regarding culture. The point was acknowledged.

AB then referred to the circulated report and highlighted the following points:
- Performance on the key safety metrics, and in particular the Safety Thermometer, had been maintained at an acceptable level
- However, "Overall Patient Satisfaction" had been on a downward trend, and needed to be closely monitored. This was likely to be related to the aforementioned recent pressures

PS then referred to the circulated report and highlighted that further details of Stroke performance would be provided in the 'Part 2' Board meeting being held later that day, though there had been some improvements.

SDu referred to the "% Harm Free Care" indicator and noted that although this was shown as improving, some of the component parts, such as Clostridium difficile, seemed to be rising. AB explained that the "% Harm Free Care" indicator only included performance on VTE Risk Assessment, Pressure Ulcers, Falls and Catheter Associated Urinary Tract Infections (CAUTIs); and provided prevalence of performance at a single point/date in time. SDu asked whether the Trust selected the date. AB confirmed that the Trust chose the date, but the same date was used each month. AB elaborated that this was usually the mid-point of the month, but was not always the same day of the week.

SM replied to SDu's comment regarding the rise in Clostridium difficile case, and gave assurance that although an increase in cases was seen, the rate of infections was not rising, due to the increased activity for the month. AB also added that for Pressure Ulcers, the numbers were low, and subject to variation, but the Trust was one of the better performing Trusts. AB accepted that Falls had increased, as had CAUTI, and acknowledged that further work was therefore required on the latter, as this was likely to be a CQUIN indicator. KT proposed that the 'main' Quality & Safety Committee undertake monitoring of CAUTIs. This was agreed.

Action: Arrange for the 'main' Quality & Safety Committee to undertake monitoring of Catheter Associated Urinary Tract Infections (Chair of Quality & Safety Committee / Director of Infection Prevention and Control, March 2015 onwards)

SO then referred to the circulated report and highlighted the following points:
- There was a deficit in-month 11 of circa £900k, and the deficit for the year to date, was £1.7m, which included 11/12^{ths} of the £12m non-recurrent deficit support funding
- Agreement had been reached with all Commissioners for 2013/14 and 2014/15, which gave certainty on income. The focus was therefore now on costs
- February saw the highest level of pay expenditure for the year, but this was not surprising, given the aforementioned pressures
- Outsourcing of activity had increased, to reduce the referral to treatment (RTT) backlog, but this was contained within the Trust's financial position
- The year-end forecast had been modified, to a £300k surplus (from a £5k surplus) to enable some flexibility
- The cash position for February was good

PB then referred to the circulated report and highlighted the following points:
- Temporary staffing had increased
- Sickness absence had reduced
- Turnover rates had reduced significantly, and this may be related to the reluctance of staff to work at neighbouring Trusts

Presentation from Clinical Director

3-8 Surgery

KT welcomed JA to the meeting. JA gave a presentation highlighting the following points:

- The Directorate had 531 WTE staff, an income of £70m, and provided Colorectal, Upper GI, Urology and Gynae oncology, as well as Emergency surgery
- The Directorate had Pye Oliver, Peale, and Cornwallis Ward at Maidstone Hospital, and Wards 10, 11, the Surgical Assessment Unit (SAU) and the Short Stay Surgical Unit (SSSU) at Tunbridge Wells Hospital. However, Pye Oliver would soon be transferred to the remit of Medicine, as it was presently affected significantly by escalation
- The Directorate also included Head and Neck care (including Ophthalmology, ENT & Audiology)
- The overall workforce of 591 WTE currently included 22 Consultants, and 153 trained Nurses. The plans for 2015/16 increased this to 23 and 242 respectively

SO queried the size of the increase in trained Nurses, and stated that he did not believe this increase was incorporated within the Directorate's business plans for 2015/16. JA accepted the need to review the planned increase, and to liaise with SO outside of the meeting.

SD asked whether the Directorate undertook radical plastics care within 'Head and Neck'. JA and AG confirmed that that was undertaken at the Queen Victoria Hospital NHS Foundation Trust.

JA then continued, and highlighted that the Directorate's key objectives came under four main categories: Develop and improve the emergency surgical service; Develop and improve effective patient pathway; Collaborative working with the CCGs; and Maintain and sustain current elective activity.

KT noted that within the 'Develop and Improve the Emergency Surgical Services' objective, there was an intention to relocate SAU, and maximise SSSU capacity, and asked for further details. JA explained the rationale behind the intention.

JA then continued and highlighted that the 'Develop and Improve Elective Patient Pathway' objective included a desire to repatriate major Urological malignancy back to Maidstone Hospital. SDu asked for further details. JA explained that the service was currently provided by Medway NHS Foundation Trust. GD noted that Cancer protocols dictated that such services were only undertaken at an accredited Unit, and there was only one such local accredited Unit. ST asked what was preventing the Trust from achieving accreditation. PS replied that achieving accreditation was a long-term process, but GD noted that this was within the Trust's longer term strategic aims.

JA then continued, and stated that the need to maximise theatre utilisation was recognised, as was the need to reduce the level of new to patient follow-up appointments, although the level the CCG required (0.8) was unlikely to be achieved. ST asked why this level was not achievable. JA stated that operating at that level meant that some patients would receive no follow-up appointment after their Surgery, which was challenging in terms of ensuring patients were provided with important post-surgery information.

JA continued, and highlighted the following points:

- In terms of activity, Surgery currently undertook: 4019 operations, 7532 endoscopies, 17,097 new clinic appointments, and 20,720 follow-ups. The plan for 2015/16 was for there to be 4258, 8132, 18,063 and 21,857 of these respectively
- Urology currently undertook: 2150 operations, 5442 new clinic appointments, and 12,576 follow-ups. The plan for 2015/16 was for there to be 2150 operations

SDu asked whether Endoscopies were undertaken by Nursing staff as well as medics. JA confirmed that this was not currently the case. SDu also referred to an action from the Quality & Safety Committee 'deep dive' meeting to explore trends in referral patterns for Urology, and suggested that the action needed to be expedited. The point was acknowledged.

SDu then asked whether the seniority of medical staff made a difference to certain care. JA stated that this was an important question, but gave assurances that the care and treatment provided within the Directorate was safe. ST asked whether there was a strategy for the ideal mix of staff, in terms of Consultants and Middle Grade doctors. JA replied that the matter was under consideration, but stated that his expectation was that in future, care would be delivered by a larger Consultant workforce than was currently the case.

JA continued, and highlighted the following points:

- For ENT, there were 2189 operations currently, but the plan for 2015/16 was to increase to this to 2331
- For Ophthalmology, there were 5944 operations, 25,878 new clinic appointments, and 76,425 follow-ups
- A number of business cases were being considered, which totalled £239k, and a number of capital bids had been submitted, which were subject to prioritisation
- The CIP target was £1.834m, but the variances within the 2015/16 budget were the subject of further work
- Key risks related to the availability of clinical capacity and space to deliver the plans. The impact of the loss of the Upper GI Cancer Surgery service was also considered to be a risk.
- Other risks relate to non-delivery of 18 week RTT target; the delivery of Cancer targets; and access to Surgical beds, due to the increase in emergency admissions
- One of the Directorate's red-rated risks related to Nursing levels on Pye Oliver Ward, but this had been addressed, though Nursing staffing at Maidstone Hospital remained a concern
- In terms of quality, there had been positive and maintained satisfaction; and a reduction in the number of open complaints
- The Directorate was confident of delivery in 2015/16, based on the delivery achieved in 2014/15

SO pointed out that the Directorate was one of the few that was achieving its financial targets, and commended the achievement of JA and his colleagues.

JA then continued, and stated that in terms of a vision for the future, the Directorate's aims included delivery of high quality healthcare; to be recognised and recommended by patients, staff and Commissioners; and creating a modern adaptive workforce to work effectively and sustainably.

SDu noted the issues that had affected the Directorate in the recent past, including escalation and cancelations, and asked JA to comment on morale within the Directorate. JA stated that there was some discomfort with the degree of escalation and its impact on Surgery, but the Directorate had managed. JA also noted that Wards 10 and 11 had substantial occupancy for an extended length of time, and this likely to recur. JA added that morale had not however been overly adversely affected by escalation.

JA then continued that the Surgery undertaken at both sites was being undertaken competently, via teams. JA elaborated by illustrating the team working within Colorectal.

KT thanked JA for his presentation.

Additional quality items

3-9 Response to the lessons to be learnt by the NHS from the Savile investigations

PB referred to the circulated report and highlighted the following points:

- The report had been discussed in detail at the Workforce Committee, and had been written with the intention of considering how the Savile report and its recommendations applied to the Trust
- A policy for managing visits by celebrities was being developed, and would be ratified in due course. Work would also be undertaken to ensure the comprehensive management of voluntary services
- Safeguarding arrangements will also be reviewed, and a report will be submitted to the Workforce Committee
- The recommendation that all NHS staff should be subject to Disclosure and Barring Scheme (DBS) checks had not been accepted by the Government, but the Trust would be implementing this step

PB added that an action plan was required to be completed by the end of May, and PB proposed that the Board obtain the assurance it needed from the Workforce Committee. This was agreed.

KT asked when the actions would be completed. PB replied that he believed all actions would be completed by the end of May 2015.

3-10 The investigation into maternity and neonatal services at University Hospitals Morecambe Bay NHS FT

AB referred to the circulated report and highlighted the following:

- A detailed response had not been included, as the report had only been issued in March
- The report had been discussed in detail at the joint Women's and Children's services Clinical Governance meeting, and it was proposed that the gap analysis be submitted to the 'main' Quality & Safety Committee
- The report was very sobering, and raised a number of concerns, such as dysfunctional teams and processes, and the independence of incident investigations
- 44 recommendations had been made, and although many were for national bodies, a number would need to be considered by the Trust

KT confirmed he was content for the gap analysis to be received at the 'main' Quality & Safety Committee, but stated that a timescale should be agreed, and also that a report should then be submitted from the Quality & Safety Committee to the Trust Board, to provide re-assurance that the issues had been addressed. KT added that he would expect the gap analysis to cover wider issues, including potential dysfunctional teams. GD stated that any Trust of similar size would have some dysfunctional teams at any point in time, and stated that it would perhaps be more appropriate to discuss such issues as part of the aforementioned Board Forum-type meeting.

AB stated that the gap analysis was expected to be submitted to the Quality & Safety Committee in May 2015. SDu agreed with KT's comments that the response needed to cover the wider lessons, relating to any other Department, and not just Maternity. AB acknowledged the point.

PS then gave assurance that the Trust's incident investigation process was critiqued by the CCG, and therefore the situation described at University Hospitals Morecambe Bay NHS FT did not accord with that at the Trust.

3-11 Clinical Quality and Patient Safety Report (to incl. update on response to the Francis Inquiry re Mid Staffs)

AB referred to the circulated report and highlighted that most of the actions arising from the Francis Inquiry had been completed, so the Board was being asked to formally consider the action plan as 'closed'. AB elaborated that the outstanding issues would be taken forward via other relevant Plans.

The Board agreed that the action plan arising from the Francis report should be formally closed, with the remaining actions taken forward via other relevant plans.

AB then highlighted that the Trust's response to two significant legislative changes (Deprivation of Liberty Safeguards (DOLs) and the Duty of Candour) had been described in the report.

KT asked what assurance could be provided that staff had learned from, and were applying, the training they had received on these two subjects. AB replied that the focus had been initially on ensuring staff received the training. PS added that the application of DOLs represented a significant cultural shift, and was being debated nationally. GD emphasised the need to apply the DOLs legislation reasonably.

3-12 Planned & actual ward staffing for February 2015

AB referred to the circulated report and highlighted the following points:

- The report now contained two "RAG" ratings: for the fill-rate and an overall rating
- The staffing on Ward 10 was the first time a Ward's actual staffing level had dropped below 80% of the planned level. AB explained that the Ward had made a conscious decision not to operate at planned staffing levels, because of the low degree of acuity and dependency of patients on the Ward at that time

- The staffing levels on Pye Oliver Ward, Ward 30 and Ward 31 were indicative of problems with recruiting to those Wards

KT asked whether the issues with the Surgical wards should be raised with JA when he attended for item 3-8. AB confirmed that the Wards came under JA's responsibility. AG added that work was underway to reconfigure the beds on such Wards, to ensure that the Surgical Wards only housed Surgical patients. AG stated that this would have a positive effect on the ability to recruit. SD asked when this reconfiguration was planned. AG confirmed that the reconfiguration was planned for May.

GD asked for an explanation of an 'amber' rating. AB explained that an 'amber' rating reflected how far the actual staffing levels were below planned levels. KT emphasised the need to review the report to ensure the focus remained on whether staffing levels were safe. AB acknowledged the point.

SO then noted that a number of the areas had staffed above their establishment, in response to the level of activity on the Ward, but clarified that establishments would not be increased until a brief case had been submitted, outlining the rationale, and confirming that an increased establishment was warranted beyond the short term.

3-13 Progress with the Quality Improvement Plan

AB referred to the circulated report and highlighted the following:
- An assurance report would be submitted to the Trust Board in April 2015
- The CQC had been asked twice to remove the Enforcement Notice regarding water quality, but had not yet done so

KT asked when the CQC would respond to the Plan. GD replied that the CQC would not provide a response, but noted that the NHS Trust Development Authority (TDA) had seen and approved the Plan before it was submitted to the CQC.

3-14 Updated declaration of compliance with eliminating Mixed Sex Accommodation

AB referred to the circulated report and invited comments or queries. None were received.

The declaration was approved as circulated.

3-15 Board members' hospital visits

KR referred to the circulated report and invited comments or queries.

SDu noted that during her recent visit with GD, it was pointed out that two members of Pharmacy staff were required to prepare a dosette box, which could, in turn, lead to delays in the issuing of discharge medication (TTOs). SDu added that there was no recognition of this level of resource by the CCG. SM concurred, and added that a dosette box took circa 4 hours to prepare, but it was a criminal offence for a Pharmacist to issue medication incorrect, which explained the level of scrutiny applied by Pharmacy staff. GD opined that it would be useful for Ward staff to see the process in action, to aid their understanding of level of resource involved, and the TTO process. KT encouraged such an approach to be adopted. SM stated that she would discuss the matter with the Chief Pharmacist, and ask him to liaise with Ward areas, perhaps by attending their Clinical Governance meetings.

Action: Request that the Chief Pharmacist liaises with Ward areas to raise awareness of the level of resource involved in the preparation of dosette boxes by pharmacy staff (Director of Infection Prevention and Control, March 2015 onwards)

Planning and Strategy

3-16 To approve the budget for 2015/16 (incl. Capital Plan)

SO referred to the circulated report and highlighted the following:
- The proposed budget had been discussed in detail at the Finance Committee held on 23/03/15
- Significant changes from the position in February had been highlighted

- The Trust had chosen to adopt the 'Enhanced Tariff Option', which was common across the NHS apart from, most notably, the Trusts within the Shelford Group (who chose to adopt the "Default Tariff Rollover")
- The main changes related to: the marginal rates for non-elective admissions and specialist activity; the marginal rate threshold of Specialist activity; A&E growth adjustment, and adjustment for CQUINs

ST reported that the Finance Committee had been reviewing the budget as it has been developed, and the Committee had been assured that the budget had been prepared diligently, and with the appropriate level of Executive involvement and scrutiny. ST added that the Finance Committee had noted that there were a number of uncertainties in the budget, and had also noted that there was currently a £6m gap in the Cost Improvement Programme (CIP); and therefore as a whole, the budget contained a range of potential outcomes. ST continued that the Finance Committee had however concluded that when taking account of the risks and opportunities in the budget, the contingencies were sufficient, and therefore the budget was commended to the Trust Board.

KT stated that he believed there was a strong grasp on the budget, which was reassuring. KT asked whether the TDA and/or CCG had responded to the level of unidentified CIP. SO replied that the Trust had made a submission to the TDA in January, and no challenge had yet been raised. SO also confirmed that the budget had not yet formally been shared with the CCG.

KT then asked for a comment on the relative proportion of recurrent and non-recurrent CIPs. SO replied that this was likely to be the subject of further discussion as the year progressed.

SO clarified that the budget was required for the start of the financial year, but two planning submissions were still required by the TDA. SO added that the contract with the CCG had not yet been agreed, and proposed that a further submission be made to the April Trust Board. This was agreed.

The budget for 2015/16 was approved as circulated.

3-17 Update on the Trust's planning submissions, 2015/16 (including approval of the latest submission to the NHS Trust Development Authority)

SO referred to the circulated report and highlighted that the process was underway, and the required submissions were expected to be submitted on time, with no problems.

KT asked for assurance that activity, financial and workforce information was triangulated. Such assurance was provided.

ST asked for assurance that, when setting the budget, there had been no compromise to patient care &/or safety. SO replied that the process involved Quality Impact Assessments, and stated that he therefore believed this was the case. ST added that he was not aware of any concerns to the contrary that had been raised by CDs. SM added that no pressure had been exerted to that effect.

3-18 Update on the implementation of the Kent Pathology Partnership (KPP)

AG reported that East Kent Hospitals NHS University Foundation Trust (EKHUFT) had asked the Shadow KPP Board that the establishment of KPP be paused whilst some Human Resources-related issues at EKHUFT were investigated and addressed. AG added that as a result, the TUPE transfer of Pathology staff had been paused. SM clarified that KPP would however still be established on 1st April 2015, and noted that a new date (1st July 2015) had been set for the TUPE transfer.

KT emphasised the importance of ensuring staff were kept informed of the latest situation and developments. SM gave assurance that staff would continue to be informed.

3-19 Approval of Full Business Case for the transformation of the procurement function

ST referred to the circulated report and highlighted the following:

- The Case had been reviewed at the Finance Committee on 23/03/15, and it had been agreed that the Case should be recommended for approval
- The Trust should be bold when determining its choice of partner

SO acknowledged ST's latter point, but cautioned that the need for a practical working relationship with a partner was the key consideration.

SO then reported that an older version of the Quality Impact Assessment for the Case had been included in Appendix IX of the circulated report, in error, and tabled the version that AB had been asked to approve (Attachment 14a). SO outlined the difference between the version circulated and that tabled.

SO added that if the Trust failed to appoint a partner, the Case would be re-submitted to the Finance Committee. ST confirmed that the Finance Committee had specifically requested this step, to ensure that efforts to recruit a partner had been exhausted.

The Full Business Case was approved as circulated, subject to AB's approval of the correct Quality Impact Assessment.

Reports from Board sub-committees (and the Trust Management Executive)

3-20 Quality & Safety Committee, 02/03/15 & 11/03/15

SDu referred to the circulated report and invited queries or comments. None were received.

3-21 Workforce Committee, 05/03/15

KT referred to the circulated report and invited queries or comments. None were received.

3-22 Patient Experience Committee, 05/03/15

SD referred to the circulated report and invited queries or comments.

KT asked about the timescale for the changes. It was agreed that revised Terms of Reference should be submitted to the Trust Board in April 2015, subject to AJ's agreement, rather than have the Terms of Reference agreed at the Patient Experience Committee before being submitted for the Board's approval.

Action: Arrange for revised Terms of Reference for the Patient Experience Committee to be submitted to the Trust Board in April 2015, for approval (Chair of Patient Experience Committee / Trust Secretary, April 2015)

3-23 Trust Management Executive, 18/03/15

GD referred to the circulated report and invited queries or comments. None were received.

3-24 Finance Committee, 23/03/15

ST referred to the circulated report and highlighted the following:

- The Committee had requested that a report be received at the Board regarding Theatre scheduling / capacity
- The Committee agreed that for operational purposes, the Trust needed to plan for a larger increase in activity from the levels that had been assumed for financial purposes

GD added that the Winter and Operational Resilience Plan would address the latter point, and AG pointed out that the Plan was scheduled to be submitted to the Trust Board in June 2015. KT proposed that the Board have a discussion in May 2015 on the assumptions underlying the Plan, ahead of the scheduled review in June 2015. This was agreed.

Action: Arrange for the May 2015 Trust Board to discuss the assumptions underlying the 2015/16 Winter and Operational Resilience Plan, ahead of the Board's review of the Plan in June 2015 (Chief Operating Officer, May 2015)

ST added that the Committee had recognised that the governance regarding the approval of contracts needed further clarity. SO stated that this would be provided via revision of the Standing Financial Instructions (SFIs), which the Board would be asked to ratify in the near future.

KT suggested that the requested report on Theatre scheduling / capacity covered broader issues relating to capacity. AG agreed to incorporate such issues.

Assurance and policy

3-25 Senior Information Risk Owner update (incl. approval of the Info. Governance Toolkit submission for 2014/15)

AB referred to the circulated report and invited comments or queries. None were received.

The Information Governance Toolkit submission was approved as circulated.

3-26 Estates and Facilities Annual Report to Board

AG referred to the circulated report and invited comments or queries.

KT commented that the report did not make much reference to backlog maintenance, and also asked whether problems relating to equipment were related to the laundry contract. GD proposed that the discussion on the latter point be held outside the meeting. This was agreed.

3-27 Review of the Board Assurance Framework, 2014/15

KR referred to the circulated report and highlighted the following:

- The Board Assurance Framework (BAF) had been updated from the version submitted to the Trust Board in January 2015, and changes were showed via the usual convention
- Board members were encouraged to consider the 7 prompts and options listed on page 208

ST stated that he wished to repeat the comments he had made at the previous Board meeting. KT noted the need for further discussion regarding ST's concerns to take place in the near future.

3-28 Approval of compliance oversight self-certification

The submission was approved as circulated.

3-29 To consider any other business

There was no other business.

3-30 To receive any questions from members of the public

AKo referred to the earlier discussion regarding dosette boxes, noted that the Trust Staff magazine was read widely, and suggested that an article be included within the magazine. This was agreed to be a useful suggestion.

Action: Arrange for an article raising awareness of the level of resource involved in the preparation of dosette boxes by pharmacy staff to be included with the Trust's staff magazine (Director of Infection Prevention and Control, March 2015 onwards)

AKo then referred to the Safety Thermometer discussion held under item 3-7, and stated that she understood that the data collection for the Safety Thermometer was undertaken on the same day each month. AB clarified that the Safety Thermometer was held on the third Wednesday of each month. KT proposed that AB explore whether the day of the week used for the collection of the monthly data could be varied. This was agreed.

Action: Explore whether the day of the week used for the collection of the monthly Safety Thermometer data can be varied (Chief Nurse, March 2015 onwards)

3-31 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – April 2015

4-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Deadline	Progress [1]
3-7 (Mar 15)	Arrange for the 'main' Quality & Safety Committee to undertake monitoring of Catheter Associated Urinary Tract Infections	Chair of Quality & Safety Committee / Director of Infection Prevention and Control	March 2015 onwards	The item has been added to the agenda of the next 'main' Quality & Safety Committee, on 13/05/15
3-15 (Mar 15)	Request that the Chief Pharmacist liaises with ward areas to raise awareness of the level of resource involved in the preparation of dosette boxes by pharmacy staff	Director of Infection Prevention and Control	March 2015 onwards	In progress
3-30 (Mar 15)	Arrange for an article raising awareness of the level of resource involved in the preparation of dosette boxes by pharmacy staff to be included with the Trust's staff magazine	Director of Infection Prevention and Control	March 2015 onwards	In progress

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
2-11 (Feb 15)	Seek the views of other organisations in relation to the management (including procurement) of medical devices	Medical Director	March 2015	The issue was discussed at a Medical Directors' network meeting on 19/03/15
2-11 (Feb 15)	Submit a report to a future Trust Board meeting containing the conclusions arising from the liaison with other organisations in relation to the management of medical devices	Medical Director	TBC	A report has been submitted to the Trust Board in April 2015
3-3 (Mar 15)	Amend the minutes of the Part 1 meeting of 25th February 2015	Trust Secretary	March 2015	The minutes were amended

[1] Not started | On track | Issue / delay | Decision required

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
3-22 (Mar 15)	Arrange for revised Terms of Reference for the Patient Experience Committee to be submitted to the Trust Board in April 2015, for approval	Chair of Patient Experience Committee / Trust Secretary	April 2015	Revised Terms of Reference have been submitted to the Trust Board in April 2015
3-30 (Mar 15)	Explore whether the day of the week used for the collection of the monthly Safety Thermometer data can be varied	Chief Nurse	March 2015 onwards	It is possible to undertake the data collection on a different day (within a fixed period of a few days), provided that this is undertaken across all sites on the same day. However, changing the current day would introduce a further variable which would affect the analysis of trends over time, and therefore the day currently used will continue.

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Deadline	Progress
2-13 (Feb 15)	Submit a report to the next Audit and Governance Committee responding to the concerns arising from the latest Internal Audit review of Consultant Job Planning	Medical Director	May 2015	The item/report has been scheduled for the Audit and Governance Committee on 6th May
3-24 (Mar 15)	Arrange for the May 2015 Trust Board to discuss the assumptions underlying the 2015/16 Winter and Operational Resilience Plan, ahead of the Board's review of the Plan in June 2015	Chief Operating Officer	May 2015	The item has been scheduled for the May 2015 Trust Board

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - April 2015

4-6	Chief Executive's update	Chief Executive

I wish to draw the issues detailed below to the attention of the Board:

1. I continued to work closely with colleagues throughout MTW during March and April, supporting the delivery of our key standards and further identifying and meeting patient needs. I attended presentations by our clinical directors on their plans to provide high standards of safe patient care in 2015/16. I was part of interview panels to recruitment new consultants in histopathology and trauma and orthopaedics.

2. We have ended our financial year with our fewest ever cases of Clostridium difficile. Thanks to the diligence of our staff, cases of C. difficile reduced by 20% in 2014/15 (28 cases) compared to the previous year (35). Our last case of MRSA was in May 2014.

3. We have outlined a £94 million package of service and environmental improvements to take place across MTW over the next five years. These support our vision to consistently provide the highest quality care to our patients whether in or outside of hospital.

   We plan to start work on the £3 million redevelopment of John Day and Jonathan Saunders Wards in June, creating a single respiratory ward with modern-day facilities greatly enhancing patient privacy and dignity. Other sets of wards are planned to be redeveloped every year thereafter at Maidstone Hospital with a total investment reaching £15 million by 2019/20.

   We plan to provide radiotherapy at Tunbridge Wells Hospital (TWH). This two-year £8 million project will provide patients with enhanced access to specialist cancer treatment, with a linear accelerator based at TWH for patients in the south of West Kent and north East Sussex.

   Our five-year plan also includes the development of new theatres at Maidstone at a cost of around £12 million, and work to enhance staff accommodation, following the completion of similar works for colleagues at TWH. The overall package of improvements transforms Maidstone, modernising facilities to deliver 21st Century care from. It is also signals our intent to have two outstanding hospitals working together for patients throughout Kent and East Sussex.

4. We are creating a new ward at TWH to improve our inpatient capacity and flows through A&E. Capacity is our key challenge at TWH following a clear increase in the age and acuity of patients requiring prolonged periods of care. This has led to a rise in the number of patients staying in hospital when they are medically fit for discharge. Our A&E departments are working well and our challenge is to ensure patients flow through our hospital beds without unnecessary delay. We are focusing on providing efficient integrated care packages for increasingly large numbers of patients who are over 85 and have more complex discharge needs. We are working with our partners throughout the local health economy to achieve this.

Which Committees have reviewed the information prior to Board submission?
- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
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Trust Board meeting – April 2015

4-7	**Reflection and response to the issues raised within the 'patient story' heard at the February 2015 Board meeting**	**Medical Director**

Summary / Key points

It was agreed at the February Board meeting to schedule an item for the 'Part 1' Board meeting in March 2015 to enable reflection and response to the issues raised within the 'patient story' heard at the February 2015 Board meeting. The enclosed report provides the Medical Director's reflection on the patient story, looking at:-

- Communication
- Medical devices
- Patient Safety Culture

Reflections on a patient story

Mr and Mrs Wilcock attended the February board meeting and described in great detail the events that had occurred from their perspective. Many members of the Trust have been heavily involved with this unfortunate event, but it was exceedingly helpful to hear how events were perceived from a different angle.

I will focus this report on the issues that failed to prevent this error and our reflections upon them.

Communication

It is clear from listening to Mrs Wilcock and from staff members, that whilst attention was being given to the patient in the recovery room, there was little attention to Mrs Wilcock and how she must have been feeling whilst her husband was away from the ward for a great deal of time. There is good documentation of 'phone calls to many other healthcare professionals, but absolutely no mention of Mrs Wilcock and also the ward staff. This is certainly an area that has been brought to the attention of the teams involved.

Medical Devices Policy and Practice

Whilst the Trust had an appropriate policy that required all proposed medical devices to pass through several gateways, a culture had developed that encouraged bypass mechanisms.

We have addressed this issue by

- Revising the policy
- Re-launching the Medical Devices Group with clinical leadership
- Changed the reporting lines of the Group in order that the links are to clinical staff who use medical devices
- Reinforced the culture that the medical devices policy and group are there to support the safe purchase and use of numerous devices by clinical staff
- Ensured greater emphasis on sufficient training for staff
- Ensure efficiency of the process

Patient Safety Culture

Several aspects of culture change have been brought to the board recently, including the introduction of a patient safety think tank and a greater customer focussed culture. In this instance, several groups of staff failed to see their role in maintaining the safety of our patients. There were opportunities to ensure more appropriate purchasing, more appropriate training and better investigation of incidents that were not taken. We are certainly trying to move the organisation to one where a "just culture" becomes embedded, and whereby we can be assured that all of our staff will contribute towards making all the care that we give as safe as possible.

Which Committees have reviewed the information prior to Board submission?

- Nil

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Discussion

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – April 2015

4-8 Management of medical devices — Medical Director

Summary / Key points

It was agreed at the February Board meeting to submit a report to a future Trust Board meeting containing the conclusions arising from the liaison with other organisations in relation to the management of medical devices. The enclosed report provides a summary of information obtained.

Following the recent HSE court case and the preceding patient injury, I was asked to liaise with other organisations to see what learning could be achieved.

I have discussed this specific case and the more generic question as to how Medical Devices are managed and the following points have arisen.

- Most Trusts have a "Technology Assessment" group that will review any device that is new to the Trust.
- A majority of my Medical Director colleagues suggest that unless a manufacturer flagged up the specifics of a "safety concern", then it is unlikely that a committee would identify the concern.
- Training and audit of training appears robust in some areas, but is variable.
- Clinical leaders of a medical devices group appear widespread.

Learning

Discussion with other organisations has shown that our processes are similar to others, with no obvious gaps in our processes. This is not surprising, given the focus that we have given to this area.

Many organisations were thankful for the issue to be raised with them.

Which Committees have reviewed the information prior to Board submission?

- None

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

For discussion

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
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Trust Board meeting – April 2015

4-9	**Integrated Performance Report for April 2015** (incorporating an update on recruitment and retention)	**Chief Executive**

The March performance follows a similar pattern to the previous months in terms of non-elective activity but with a slight increase in both the A&E attendances and admissions. However the main issue in March was the severe spike in delayed transfers of care which rose to 6% (1250 beds days lost). The key reasons for the increased number are social services related, where West Kent is impacted by poor nursing home and residential home capacity, inability to provide timely enablement packages and delays in providing domiciliary care packages. As a Trust we recognise this as one of our key risks and priorities and have taken specific actions to escalate and address the issues and continue to work with partners to highlight concerns. The focus of our "breaking the cycle" week was on patient discharge, specifically delayed transfer of care and complex discharges. Subsequent meetings at CEO level between the responsible parties have taken place and will continue through the West Kent System Resilience Forum.

The impact of this can also be seen in the average length of stay at 7.3 days and the average occupancy for the Trust which has remained high at 685 patients a night. This level of beds open reflects the continued use of escalation beds on both sites which resulted in significant numbers of bank and agency staff being used as reported in the workforce section.

The RTT performance and elective activity levels achieved in March required an increased level of outsourcing to private providers but which has enabled performance to continue at the activity levels seen in the previous month and day case performance has continued to improve. This, combined with a small reduction in cancellations, ensured the Trust was able to continue to reduce its 18 week backlog and achieve a sustainable level by 31 March.

The Trust has incurred a total of four 52 week breaches in the year, all in the same directorate and all with similar findings from the root cause analysis investigations. The delays to treatment has not caused harm to the patients involved and as a result of the issues raised we have engaged the services of our internal audit department to do a more thorough review of systems and processes in the Head & Neck department.

As mentioned last month the performance on cancer targets in February (reported a month in arrears) continued to underperform but is in line with the trajectory and the plans previously shared.

Despite the pressure and high levels of occupancy there were no C Diff cases in March and the rates for readmissions, complaints and falls remained stable. We did see an increase in the number of hospital acquired pressures ulcer. These are all grade 2 ulcers and half of these are heels. There is specific reason or change in practice that would account for this increase and for April the incidence is back within normal levels.

The enclosed report includes, as usual, the Trust performance dashboard; integrated performance charts; and financial performance overview.

Further details on recent recruitment and retention will be provided verbally at the meeting.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 15/04/15
- Executive Team, 21/04/15

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Discussion and scrutiny

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

TRUST PERFORMANCE DASHBOARD — **Position as at:** **31st March 2015**

Governance (Quality of Service):	**2.0**	**Amber/Red**
Finance:	**2.5**	**Amber**

Responsible Committee: Quality & Safety

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

Please note a change in the layout of this Dashboard with regard to the Finance & Efficiency and Workforce Sections

	Patient Safety & Quality	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	Hospital-level Mortality Indicator (SHMI)	Prev Yr: July 12 to June 13		100.3	101.5	1.2	1.5	*100*		100
'1-02	Standardised Mortality (Relative Risk)	Prev Yr: April 13 to Mar 14		104.2	109.0	4.8	9	*100*		100
'1-03	Crude Mortality	1.1%	1.1%	1.2%	1.2%	-0.1%				
'1-04	Safety Thermometer % of Harm Free Care	96.9%	97.6%	95.4%	96.7%		1.7%	95.0%		0.0%
'1-05	*Rate C-Diff (Hospital only)	15.0	0.0	15.7	12.0	-3.6	-5.1	*15.7*	12.0	15.7
'1-06	Number of cases C.Difficile (Hospital)	3	0	35	28	-7.0	-12.0	*35*	28	35
'1-07	Number of cases MRSA (Hospital)	0	0	3	1	-2	0	*0*	1	
'1-08	Elective MRSA Screening	No data	99.0%	No data	99.0%		1.0%	98.0%	99.0%	
'1-09	% Non-Elective MRSA Screening	97.0%	97.0%	97.0%	97.0%		2.0%	95.0%	97.0%	
'1-10	**Rate of Hospital Pressure Ulcers	1.2	3.6	2.3	2.4	0.1	-0.6	*3.0*	2.4	3.0
'1-11	****Rate of Total Patient Falls	6.4	5.7	7.1	6.2	-1.0	-0.6	6.75	6.2	
'1-12	****Rate of Total Patient Falls Maidstone	5.9	6.2	6.3	5.2	-1.1	-1.5		5.2	
'1-13	****Rate of Total Patient Falls Tunbridge Wells	6.2	5.2	7.7	6.9	-0.9	0.1		6.9	
'1-14	Falls - SIs in month		5		36	36				
'1-15	MSA Breaches	0	0	10	68	58	68	0	68	
'1-16	Total No of SIs Open with MTW	24	32			8				
'1-17	Number of New SIs in month	9	16	129	118	-11	-2			
'1-18	Number of Never Events	0	0	1	2	1	2	*0*	2	
'1-19	Number of CAS Alerts Overdue	2	0			-2	0	*0*		
'1-20	*****Readmissions <30 days: Emergency	12.5%	11.9%	11.3%	11.6%	0.3%	-2.0%	*13.6%*	11.6%	14.1%
'1-21	*****Readmissions <30 days: Elective	7.0%	6.5%	5.8%	5.5%	-0.3%	-0.8%	*6.3%*	5.5%	6.8%
'1-22	***Rate of New Complaints	5.8	3.93	5.1	4.08	-1.0	-2.18	*6.26*	4.08	6.26
'1-23	% complaints responded to within target	83.3%	69.0%	57.8%	68.0%	10.1%	-7.0%	75.0%	68.0%	
'1-24	IP Resp Rate Recmd to Friends & Family	17.1%	29.6%	17.2%	39.7%	22.5%	9.7%	**30% Q4**	39.7%	40.1%
'1-25	A&E Resp Rate Recmd to Friends & Family	7.0%	17.2%	4.8%	18.1%	13.3%	-1.9%	**20% Q4**	18.1%	20.1%
'1-26	Mat Resp Rate Recmd to Friends & Family	New	20.9%	New	18.9%	New	-1.1%	15%	18.9%	22.9%
'1-27	IP Friends & Family (FFT) Score	79	81	76	77	1	4	73	77	73
'1-28	A&E Friends & Family (FFT) Score	67	62	66	63	-3	7	56	63	56
'1-29	Maternity Combined Q1 to Q4 FFT Score	New	86	New	84	New	12	72	84	72
'1-30	Five Key Questions Local Patient Survey	91.8%	89.4%			-2.4%		90%	89.4%	
'1-31	VTE Risk Assessment (Feb)	95.1%	95.1%	95.2%	95.5%	0.3%	0.5%	95%	95.5%	95%
'1-32	% Dementia Screening	98.7%	99.6%	98.9%	98.9%	0.0%	8.9%	90%	98.9%	
'1-33	% TIA with high risk treated <24hrs (Dec)	No data	73.3%	63.6%	74.4%			60%	74.4%	
'1-34	% spending 90% time on Stroke Ward (Mar)	80.4%	80.9%	76.9%	81.6%	4.7%	1.6%	80%	81.6%	
'1-35	Stroke:% to Stroke Unit <4hrs (Feb)	New	39.5%	New	39.4%	New	New	55.0%	39.4%	
'1-36	Stroke: % scanned <1hr of arrival (Feb)	New	53.8%	New	43.9%	New	New	43.0%	43.9%	
'1-37	Stroke:% assessed by Cons <24hrs (Feb)	New	66.7%	New	73.1%	New	New	85.0%	73.1%	

Responsible Committee: Finance, Treasury & Investment

	Finance & Efficiency	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Average LOS Elective	2.8	3.1	3.2	3.2	-0.1	-0.1	*3.3*	3.2	3.3
3-02	Average LOS Non-Elective	7.1	7.3	6.8	6.9	0.0	1.2	*5.7*	6.9	5.7
3-03	New:FU Ratio	1.66	1.60	1.71	1.55	-0.16	0.03	*1.52*	1.55	
3-04	Day Case Rates	78.5%	83.4%	79.7%	83.6%	4.0%	3.6%	80.0%	83.6%	82.19%

	Finance & Efficiency	Latest Month *Plan*	Latest Month Curr Yr	Year to Date *Plan*	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan	Year End Forecast	Bench Mark
3-05	Income	32,351	39,496	380,341	403,247	7.3%	6.0%	380,341	403,247	
3-06	EBITDA	3,482	5,870	24,718	35,319	59.1%	42.9%	24,718	35,319	
3-07	Surplus (Deficit) against B/E Duty	268	2,727	(12,303)	163			(12,303)	163	
3-08	CIP Savings	2,099	2,232	22,400	23,796	1.2%	6.2%	22,400	23,796	
3-09	Cash Balance	926	3,796	926	3,796	-71.3%	309.9%	926	3,796	
3-10	Capital Expenditure	3,552	8,475	16,683	14,008	26.8%	-16.0%	*16,683*	14,008	
3-11	**Monitor Continuity of Service Risk Rating**	New	3	2	3	New	1	2	2.5	

** Contracted not worked WTE including Maternity/Long Term Sickness etc.

Responsible Committee: Finance, Treasury & Investment

	Performance & Activity	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	**Monitor Indicative Risk Rating**	**1.5**	**2.0**	**1.5**	**2.0**	**Amber/Red**		**Amber/Red**		
2-02	Emergency A&E 4hr Wait (SITREP Wks)	96.1%	89.3%	95.6%	92.02%	-3.6%	-3.0%	95%	92.0%	94.6%
2-03	Emergency A&E >12hr to Admission	0	0	0	2	2	2	0	2	
2-04	***Ambulance Handover Delays >30mins	New	No data	New	No data	New		365	No data	
2-05	***Ambulance Handover Delays >60mins	New	0	New	0	`	0	0	0	
2-06	18 week RTT - admitted patients	91.0%	91.4%	91.7%	91.5%	-0.2%	1.5%	90%	91.5%	
2-07	18 week RTT - non admitted patients	96.3%	97.2%	96.6%	96.9%	0.3%	1.9%	95%	96.9%	
2-08	18 week RTT - Incomplete Pathways	93.6%	97.3%	93.6%	97.3%	3.7%	5.3%	92%	97.3%	
2-09	18 week RTT - Specialties not achieved	2	5	33	31	-2	31	*0*	31	
2-10	18 week RTT - 52wk Waiters	0	3	1	4	3	4	*0*	4	
2-11	18 week RTT - Backlog 18wk Waiters	817	443	817	443				443	
2-12	% Diagnostics Tests WTimes <6wks	100.0%	100.00%	100.0%	99.96%	0.0%	1.0%	99.0%	99.96%	
2-13	Cancer WTimes - Indicators achieved	8	6	9	8	-1	-1	9	8	
2-14	*Cancer two week wait	94.4%	96.1%	94.4%	96.1%	1.7%	3.1%	93%	96.1%	95.5%
2-15	*Cancer two week wait-Breast Symptoms	93.1%	96.9%	93.1%	94.8%	1.7%	1.8%	93%	94.8%	
2-16	*Cancer 31 day wait - First Treatment	99.4%	99.4%	99.4%	98.4%	-0.9%	2.4%	96%	98.4%	98.4%
2-17	*Cancer 62 day wait - First Definitive	83.6%	84.4%	83.6%	82.4%	-1.1%	-2.6%	85%	82.4%	87.1%
2-18	Delayed Transfers of Care	3.1%	6.0%	3.3%	4.2%	0.9%	0.7%	3.5%	4.2%	
2-19	Primary Referrals	8,363	9,565	94,744	103,394	9.1%	11.0%	93,129	103,394	
2-20	Cons to Cons Referrals	2,944	3,178	42,239	40,728	-3.6%	-4.0%	42,433	40,728	
2-21	First OP Activity	11,765	12,158	146,268	143,014	-2.2%	5.7%	135,344	143,014	
2-22	Subsequent OP Activity	21,739	22,224	252,780	258,679	2.3%	3.4%	250,125	258,679	
2-23	Elective IP Activity	781	723	8,850	7,734	-12.6%	-19.3%	9,584	7,734	
2-24	Elective DC Activity	2,731	3,691	34,056	37,802	11.0%	-2.1%	38,602	37,802	
2-25	Non-Elective Activity	4,177	4,148	46,699	47,308	1.3%	4.2%	*45,404*	47,308	
2-26	A&E Attendances (Calendar Mth)	11,210	10,857	125,180	130,315	4.1%	4.1%	*125,139*	130,315	
2-27	Oncology Fractions	5,854	5,842	67,071	69,902	4.2%	3.0%	67,876	69,902	
2-28	No of Births (Mothers Delivered)	474	507	5,391	5,708	5.9%	7.5%	5,310	5,708	
2-29	Midwife to Birth Ratio	New	1:28	New	1:28	New	0.00	1.28	1:28	
2-30	C-Section Rate (elective & non-elective)	27.8%	24.5%	25.8%	27.1%	1.4%	2.1%	25.0%	27.1%	
2-31	% Mothers initiating breastfeeding	77.4%	79.3%	81.8%	81.5%	-0.3%	3.5%	78.0%	81.5%	
2-32	Intra partum stillbirths Rate (%)	0.2%	0.6%	0.4%	0.3%				0.3%	

* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Complaints per 1,000 Episodes (incl Day Case), **** Rate of Falls per 1,000 Occupied Beddays, ***** Readmissions run one month behind.

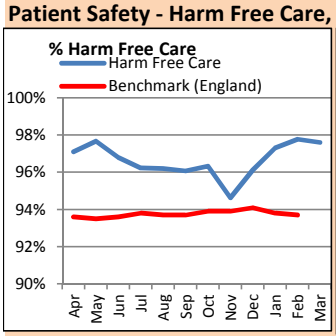
Responsible Committee: Workforce

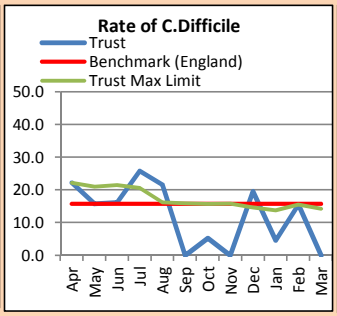
* Stroke & CWT run one mth behind, *** Ambulance Handover is unvalidated

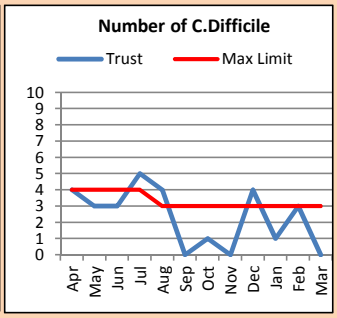
	Workforce	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ Limit	Year End Forecast	Bench Mark
4-01	Establishment (Budget WTE)	5,362.3	5,492.4	5,362.3	5,492.4	2.4%	0.0%	*5,492.4*	5,492.4	
4-02	Contracted WTE	4,984.2	5,002.2	4,984.2	5,002.2	0.4%	-5.1%	*5,273.4*		
4-03	**Contracted not worked WTE		(96.0)		(96.0)					
4-04	Locum Staff (WTE)	23.3	22.4	23.3	22.4	-3.8%				
4-05	Bank Staff (WTE)	270.3	411.0	270.3	411.0	52.0%				
4-06	Agency Staff (WTE)	114.9	323.4	114.9	323.4	181.5%				
4-07	Overtime (WTE)	68.0	75.9	68.0	75.9	11.7%				
4-08	Worked Staff WTE	5,325.4	5,721.6	5,325.4	5,721.6	7.4%	3.3%	*5,538.6*		
4-09	Vacancies WTE	378.1	490.2	378.1	490.2	29.6%			490.2	
4-10	Vacancy %	7.1%	8.9%	7.1%	8.9%	26.6%			8.9%	
4-11	Nurse Agency Spend	(297)	(744)	(4,030)	(5,853)	45.2%			(5,853)	
4-12	Medical Locum & Agency Spend	(473)	(979)	(7,840)	(10,212)	30.3%			(10,212)	
4-13	Staff Turnover Rate	10.0%	9.4%		9.32%	-0.6%	-1.1%	*10.5%*	9.32%	8.4%
4-14	Sickness Absence	3.9%	4.2%		4.1%	0.3%	0.9%	*3.3%*	4.1%	3.7%
4-15	Statutory and Mandatory Training	86.5%	85.6%		85.6%	-0.9%	0.6%	85.0%	85.0%	
4-16	Appraisals	82.4%	82%	76.3%	82%	-0.5%	-8.2%	90.0%	82.0%	

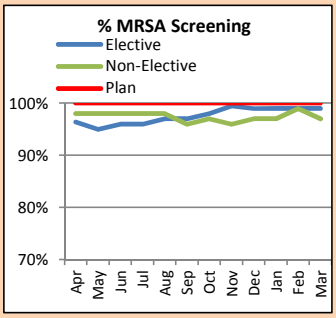
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

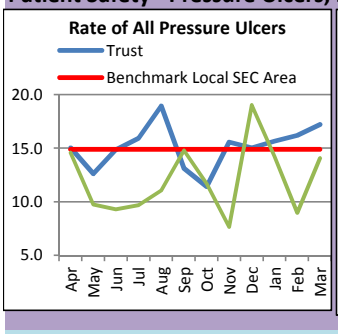


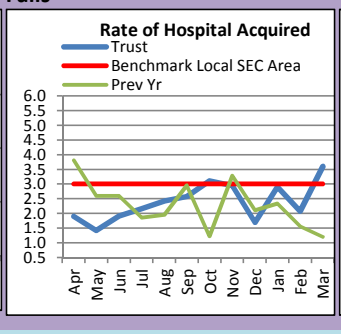


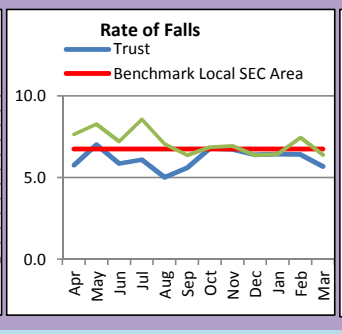


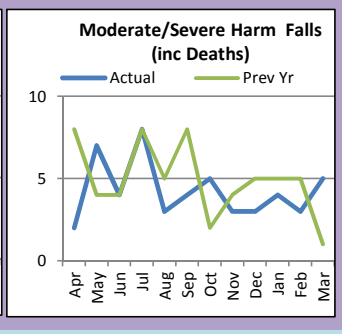


Patient Safety - Pressure Ulcers, Falls

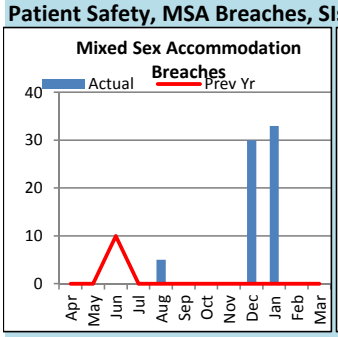


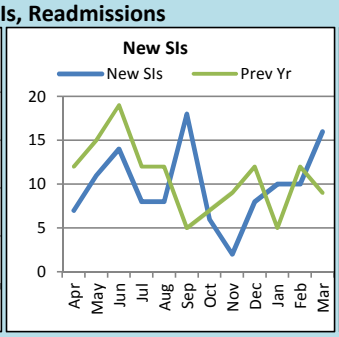


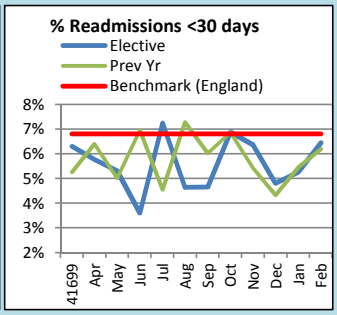


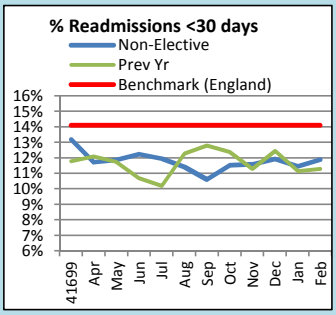


Patient Safety, MSA Breaches, SIs, Readmissions

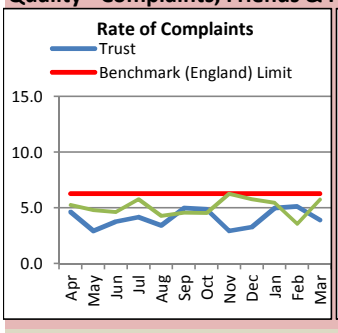


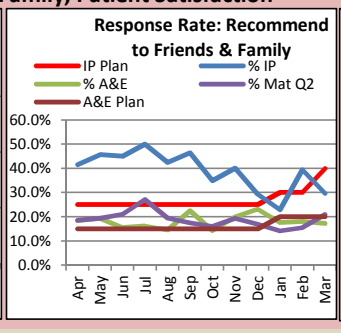


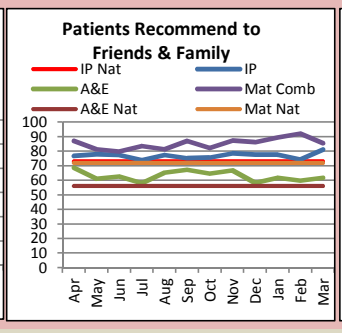


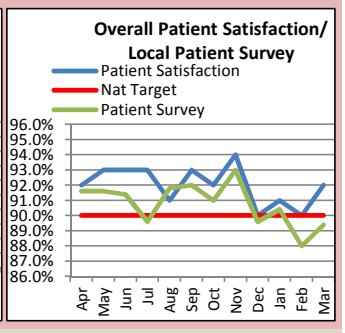


Quality - Complaints, Friends & Family, Patient Satisfaction

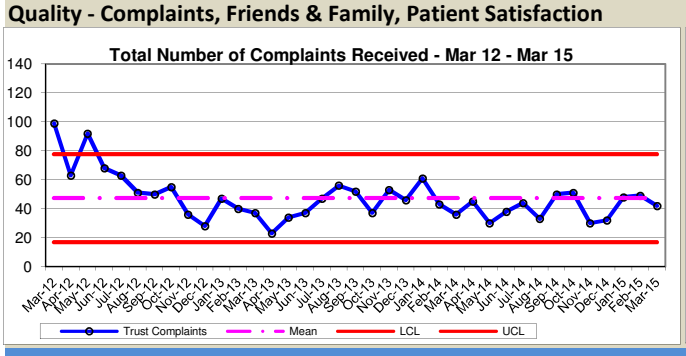


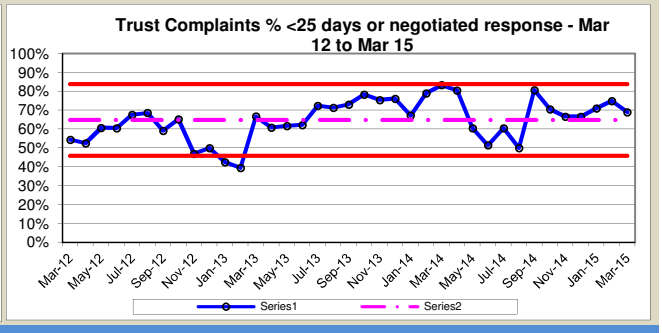




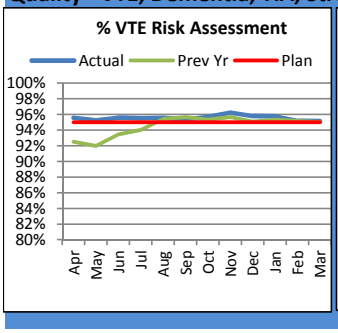


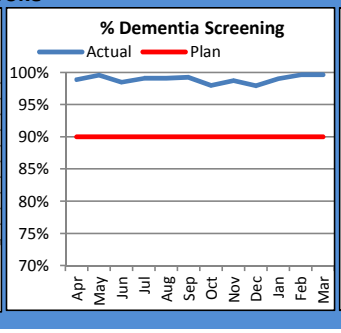
Quality - Complaints, Friends & Family, Patient Satisfaction

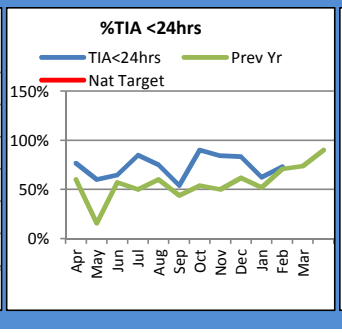


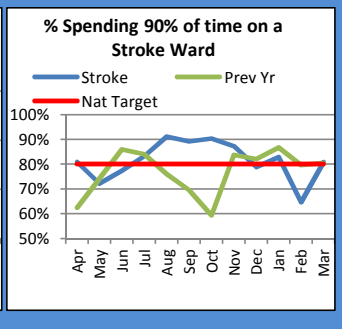


Quality - VTE, Dementia, TIA, Stroke



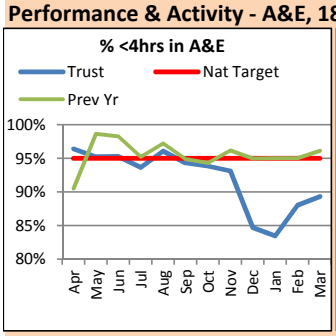


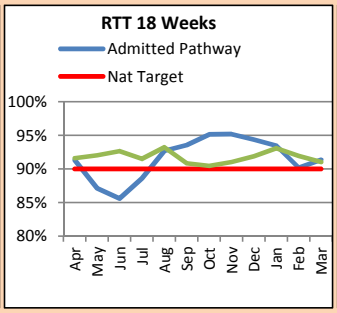


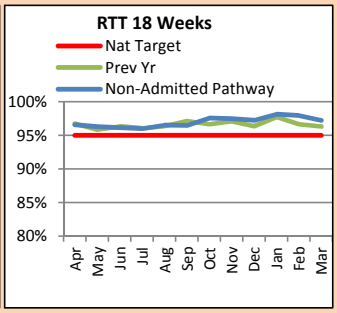


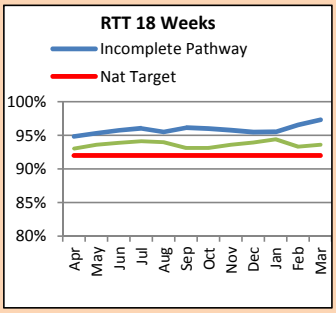
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

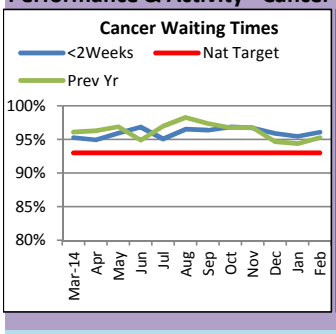


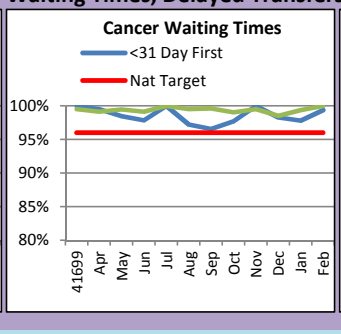


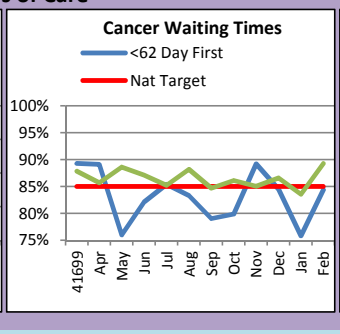


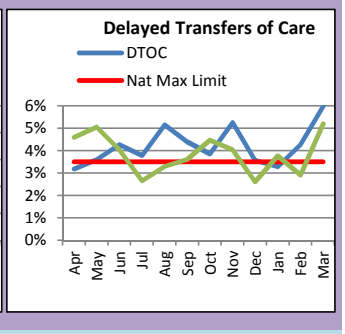


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

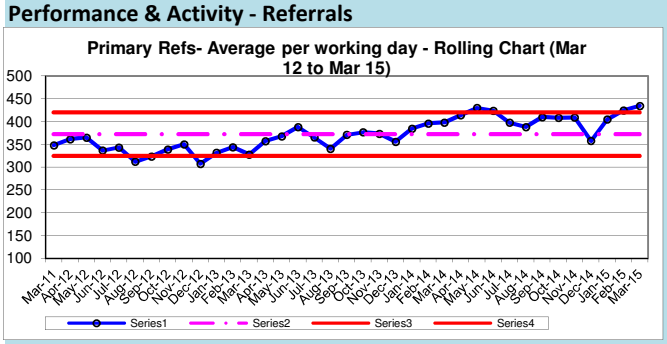


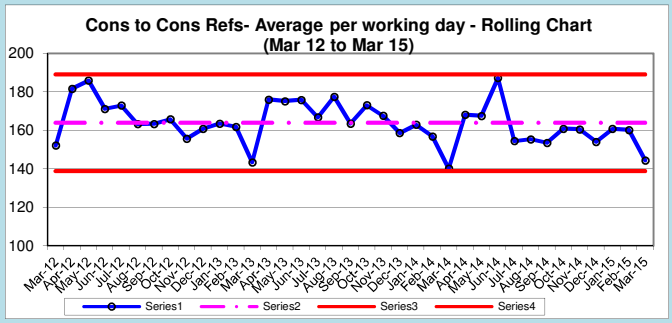




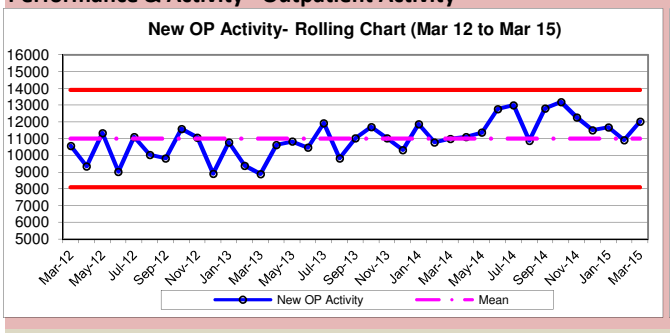


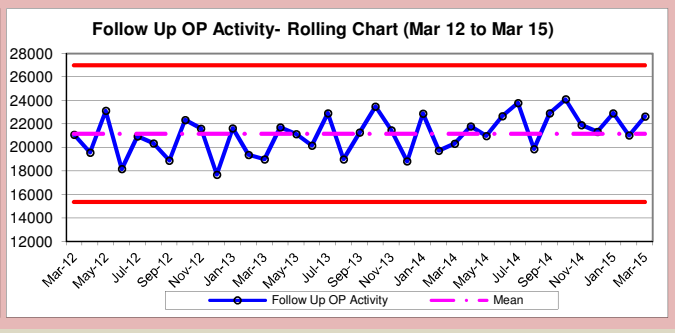
Performance & Activity - Referrals



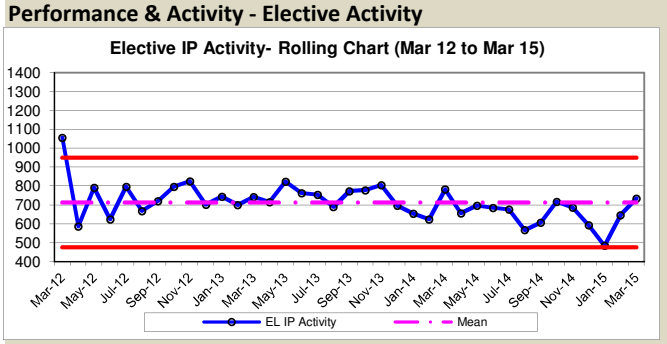


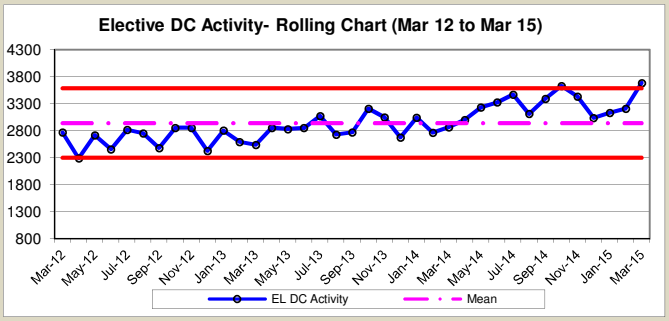
Performance & Activity - Outpatient Activity



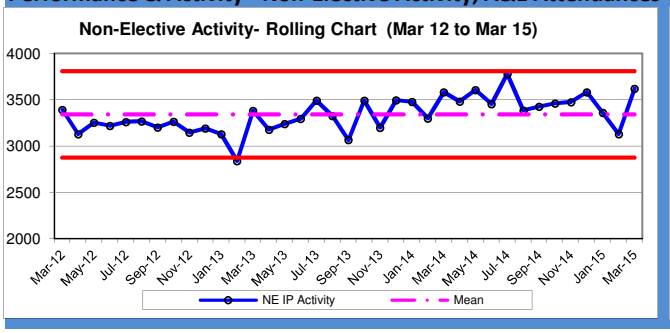


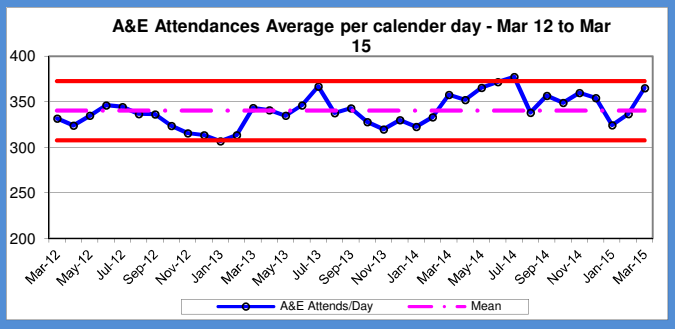
Performance & Activity - Elective Activity





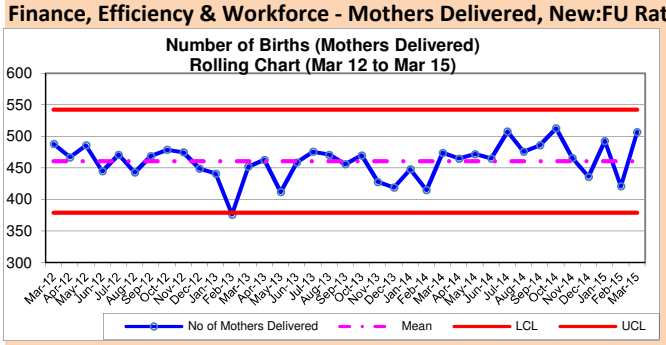
Performance & Activity - Non-Elective Activity, A&E Attendances

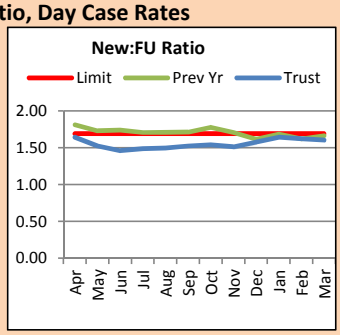


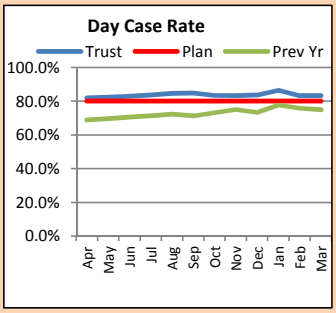


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

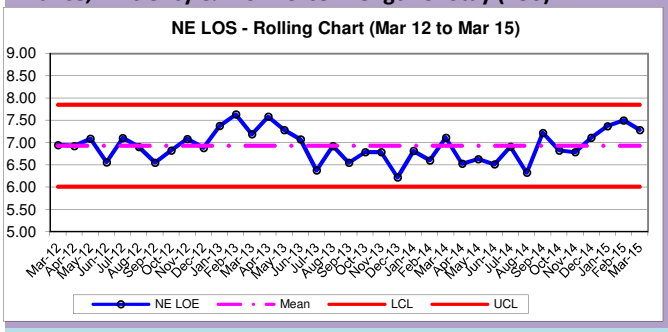
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

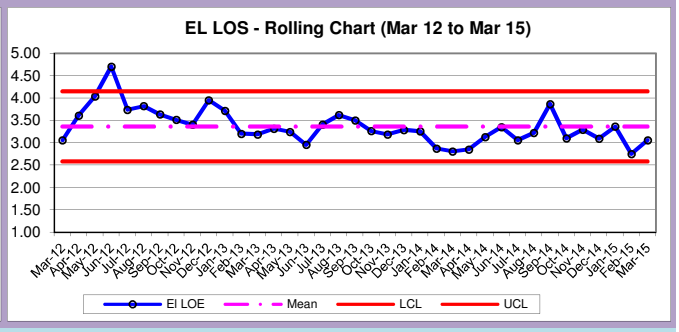




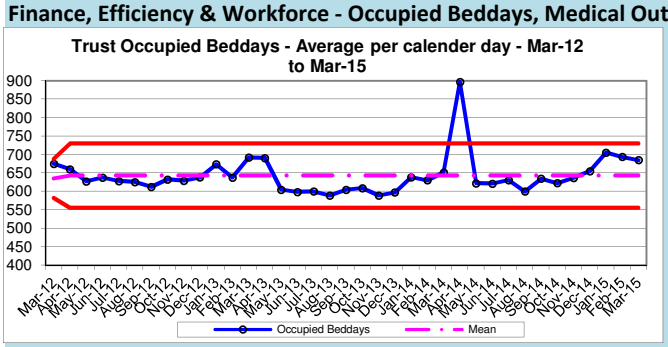


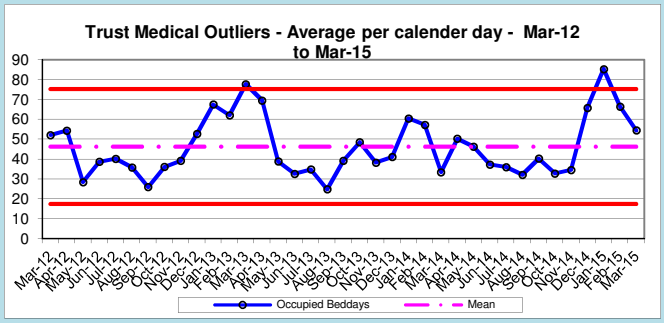
Finance, Efficiency & Workforce - Length of Stay (LOS)



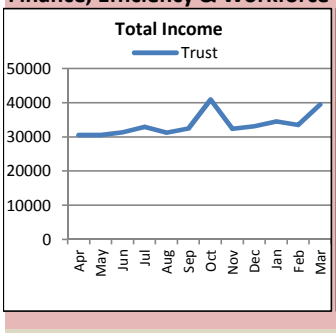


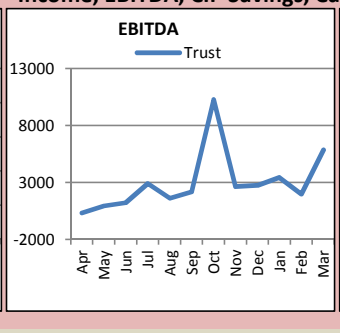
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

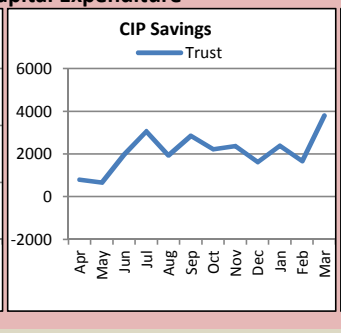


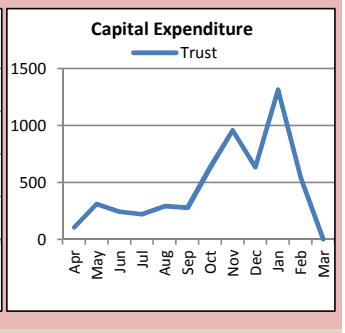


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

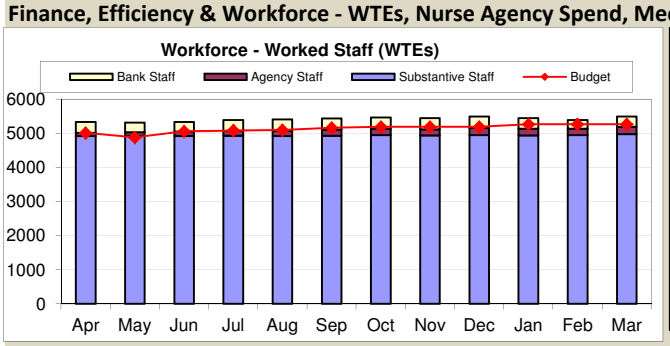


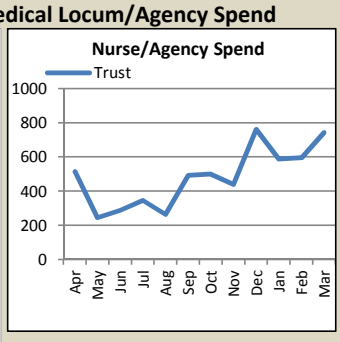


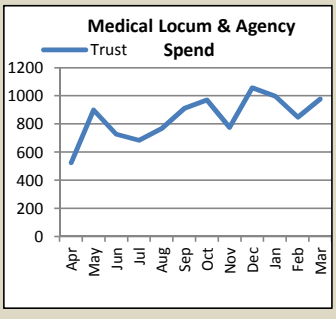




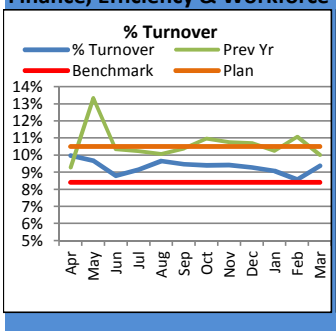
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

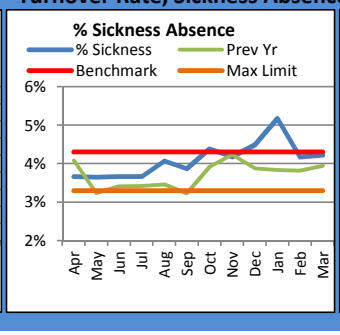


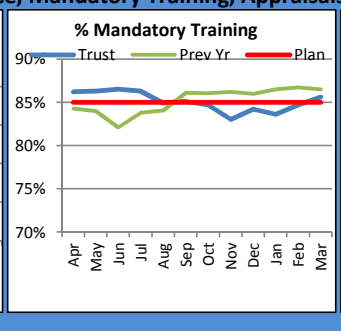


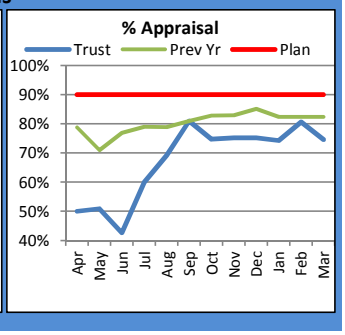


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









M12 Financial Performance overview

1. Overview of the Financial Position at M12 2014/15

1.1. This written summary provides an overview of the financial position at M12 of 2014/15. It should be read alongside the detailed finance pack, which has also been circulated to Finance Committee members.

1.2. The Finance pack shows for Month 12 an in month surplus of £2.73m against a surplus plan of a £0.27m (£2.46 m favourable movement) resulting in a year end surplus of £0.2m against a planned deficit of (£12.3m), resulting in a favourable overall variance to plan of £12.5m.

1.3. Sustained levels of high bed occupancy due to increasing non elective demand and 6% of beds filled with delayed discharge of care patients and an increasing proportion of patients over the age of 75 have put significant financial pressure on the Trust in March.

1.4. The in month favourable movement of £2.5m includes

- £1m related to inclusion of 1/12th of the £12m non-recurrent deficit support funding as notified by the TDA. Part of the £12m of funding for the whole year.
- Recognition of the net £2.3m settlement 2013/14 contracts.

1.5. The total year to date total income is £403.2 m against a budget of £380.3m; an over performance of £22.9m, (£7.1m over performance in the month). Of the Month 12 favourable variance the following areas provided the more material variances:

- £1.0m relates to 1/12ths of the £12m deficit support funding as highlighted in 1.3 above,
- £2.3m of income recognised from 2013/14 as contracts were resolved.
- A further £1.7m has been released from provisions as disputes relating to contracts for 2014/15 are resolved with resultant benefits released into the month 12 position.
- Private patient income was £0.2m over plan in March.
- £0.3m of HIS recharges for 2014/15.
- £0.9m of income debtor raised to mirror the Redundancy provision made for HIS staff.

1.5. March saw the second highest level of non-elective activity seen in 2014/15 with only July being higher. March's non elective activity was higher than the plan by 4.2%. A&E continued to see the same high level of daily attendances it has seen throughout the winter. In 2014/15 The Trust was deducted a total of £7.8m as contracting rules for 2014/15 state that the Trust can only get paid 30% of the emergency admission income it earns above its 2008/09 level. In March the income generated by the high level of emergency admission activity caused a £1.4m deduction for the threshold. This was the highest deduction made all year. The yearend agreement with CCGs mitigated this impact but it should not be ignored because the Trust will get paid only 70% of the income above 2008/09 levels during 2015/16.

1.6. Operating costs are £367.9m against a plan of £360.2m, an adverse variance of £7.8m (£3.7m adverse in the month).

1.7. Pay was overspent by £1.9m in the month and is £5.0m overspent for the year. In actual expenditure terms the Trust experienced another month of very high pay costs £21.2m (compared to the previous highs in December and February of £20.2m) which was also £1.6m above the mean of the previous 11 months. The March pay costs would still be higher than February's even if a one off provision to recognise the potential cost associated with HIS redundancies was removed from the months spend. The key variances remain in Nursing and Medical staff, with significant pressures being still being in premium cost temporary staffing. Although the number of escalation beds reduced by the end of the month the number of total occupied days was at the similar high level seen in January and February. This with the increasing proportion of over 75's provides a backdrop to the spend patterns seen in recent months.

1.8. Non pay overspent by £1.7m in month and is now £2.8m overspent year to date. The Purchase of healthcare from non NHS bodies was a significant adverse variance in the month (£0.9m) and the year-end underspend has reduced to £1.5m. Non pay costs in March were higher than the mean spending of the prior 11 months by £1.6m, with the purchase of Healthcare being a significant driver. Drugs were also overspent to plan by £0.4m but as High cost Drugs were over plan by £0.6m this represents a reduction in non-chargeable drug costs. Year-end stock adjustments had an adverse impact on the Clinical Supplies budget in month of £0.2m.

1.9. EBITDA is £35.3m which is ahead of plan by £10.6m year to date (£2.4m in month) against the plan.

1.10. The financing costs including those related to the PFI and deprecation totalled £50.3m, which is now overspent against the annual plan by £11.2m (£12.8m overspent in month). This significant swing in variance is as a result of the recognition of impairments (£14.2m) which was in part offset in the month by the underspend against Public Dividend Capital (£0.2m) and Depreciation (£0.4m).

1.11. The CIP delivery for the year is £23.8m against a target of £22.4m.

1.12. Cash balances of £3.8m were held at the 31st March 2015. An unexpected advance of cash from NHS Education lifted the cash balance above the allowed £1m.

1.13. The continued improved cash position has allowed a more normal level of payment runs with some reduction to the backlog of creditors' payments.

1.14. Total debtors are £33.4m (£47.8m in M11). This reduction is a result of the settlements for 2014/15 (as signalled last month) and in particular a payment of £5m received from the SCG.

1.15. Total creditors are £32.9m (£58.3m in M11).

1.16. Capital expenditure for the year totalled £13.4m (including the Canterbury Linear Accelerator cancer treatment machine £2.7m) .

1.17. The Trust's performance against the TDA Accountability framework is Amber due to the receipt of the £12m deficit support funding.

2. Income review and outstanding issues

2.1 2013-14 position update – All the 2013/14 contracts are now agreed and invoiced for.

2.2 In year performance - The Trust is reporting a £18.3m (6%) favourable variance against the Trusts internal plan. The reason for the over performance is mainly due to the receipt of the deficit support funding from the TDA. The Trust continued to see high levels of emergency demand which led at points to unplanned increases to both bed occupancy and expensive temporary staffing. In addition, a number of planned Elective procedures had to be cancelled in order to accommodate the extra emergency patients, leading to a further shortfall in elective income, which was slightly mitigated by the heavy reliance on the private sector to keep the flow of Elective activity going.

- Elective Inpatients have a £5.4m (19%) adverse variance against the annual plan. The plan included a £1.9m of outsourced income relating to planned clearance of 18 week backlog activity. The balance of the adverse variance of £3.5m relates to the continued difficulties in driving elective activity due to a combination of bed pressures within the Trust, shortfall in activity being undertaken by the Private sector and other operational pressures arising from the significant increase in Non-elective activity.

- Non Elective Threshold is £3.9m (98%) above the annual plan. The Trust has experienced record levels of emergency demand which is evidenced by the increased throughput within the A&E and emergency directorates; these have increased the emergency threshold penalty levied under the NHS Standard contract.

- Outpatient follow ups have a £2.2m (8%) favourable movement against the internal plan for the year. The Trust continues to see large volumes of follow up activity primarily in Surgical and Medical specialties, all of which are subject to CCG follow up SLA restrictions and are incurring penalties.

- Outpatient unbundled imaging has a £0.9m (11%) favourable variance against the year to date phased plan. This is in line with the over performance in First and Follow up Outpatient attendances.

- A 95% achievement level has been reflected in the accounts in line with the yearend agreement with CCGs. The focus now is on delivering the CQUINs targets for 2015/16. The structure of a CQUIN board and leads being identified for each CQUIN key performance indicator will remain.

- Transitional Support – Cancer - £5.8m – This relates to the transitional support received from NHS England to reduce the impact of the cancer tariff in 2014-15, this income is reduced by 50% in 2015-16 and removed completely in 2016-17. The Trust will have to take appropriate steps to reduce its expenditure base accordingly.

Expenditure review

3.1 Total pay is now at £2.5m overspent as a result of with a significant in month over spend of £1.9m in Month 12. Worked WTE's at M12 are 5,722 , an effective over establishment

of 183 against the Trust budget of 5,539 and represents an increase of an effective 49 WTE since February . The key financial variances are outlined below :

- Medical pay is overspent by £2.8m for the year (£0.4m adverse in month). Substantive posts are under spending by £3.0m however temporary staff used to cover these vacancies and other temporary cover requirements is costing £5.8m putting costs above the funding based on the Directorate workforce plans.

	Year to Date		
	Budget	Actuals	Variance
Directorates	**£'000s**	**£'000s**	**£'000s**
Clinical Directorates			
Surgery	(13,322)	(13,926)	(604)
T&O	(4,347)	(4,672)	(325)
Critical Care	(8,560)	(8,090)	470
Emergency & Medical Services	(17,277)	(18,935)	(1,658)
Cancer & Haematology	(4,950)	(4,913)	36
Diagnostics, Therapies & Pharmacy Services	(6,578)	(6,808)	(230)
Obstetrics, Gynaecology & Sexual Health	(4,607)	(4,730)	(123)
Paediatrics	(3,692)	(3,602)	90
MTW-Healthcare	(633)	(941)	(308)
Total Clinical Directorates	**(63,966)**	**(66,618)**	**(2,652)**
Total Corporate Directorates	**(604)**	**(698)**	**(94)**
Non Directorate	0	(107)	(107)
Total Trust	**(64,570)**	**(67,423)**	**(2,853)**

Activity, bed and absence driven agency and locum spend in March exceeded budget buy £0.7m. Patterns of spend in February and March are of concern and work plans to review the causes and to revise control processes are being drawn up.

- Nursing pay is (£3.3m) above the plan year to date (£0.6m adverse in month caused by increased levels of Nurse Agency and Bank).

	Year to Date		
	Budget	Actuals	Variance
Directorates	**£'000s**	**£'000s**	**£'000s**
Clinical Directorates			
Surgery	(10,139)	(10,433)	(295)
T&O	(3,109)	(3,250)	(141)
Critical Care	(12,086)	(11,771)	316
Emergency & Medical Services	(29,032)	(31,865)	(2,833)
Cancer & Haematology	(2,812)	(3,255)	(443)
Diagnostics, Therapies & Pharmacy Services	(888)	(813)	75
Obstetrics, Gynaecology & Sexual Health	(11,752)	(12,078)	(327)
Paediatrics	(4,939)	(5,120)	(181)
MTW-Healthcare	(1,916)	(1,609)	308
Total Clinical Directorates	**(76,673)**	**(80,193)**	**(3,519)**
Total Corporate Directorates	**(3,263)**	**(2,904)**	**358**
Non Directorate	0	(169)	(169)
Total Trust	**(79,936)**	**(83,266)**	**(3,330)**

The Emergency & Medical Services Directorate Nursing overspent by £2.8m at year end which included the impact of unfunded escalation beds (£0.8m). Across the Trust staff absences and activity and acuity pressures have been sighted as reasons for the recruitment of temporary nursing staff. In order to control expenditure prior to the

delivery of 2015/16 plan a review of staffing controls and the reporting and management of temporary staff will be required.

- Scientific & Therapeutic staff is under spending by £1.4m, Cancer, Therapies and Pathology have significant level of vacancies that were not fully covered by temporary staff cover.

- Within Admin and Clerical the recognition of potential HIS redundancies has caused an adverse £0.9m adverse variance against plan in March. This has left the overall budget adverse to plan by £0.1m.

3.2 After adjusting for one off events (Novell Licence dispute provision and year end stock adjustments) Non-Pay budgets were overspent by £1.8m in the month and overall is overspent by £2.8m for the year. The main overspends in month related to outsourcing work with independent providers and other NHS providers (£0.6m) , Drugs (£0.4m driven by recharged High Cost Drug spend) and other areas continuing at the levels seen since January.

3.3 Below EBITDA costs excluding impairments which are treated as technical for the Trusts breakeven duty are underspent by £3.1m (£0.6m underspent in month) due to the year to date impact of the revised calculation of PDC based on the forecast statement of financial position (including the expectation of an impairment of assets) as opposed to the original plan and the review of the capital programme has impacted by reducing depreciation.

4 CIP Delivery

4.1 At year end £23.8m of CIPs have been delivered against a full year target of £22.4m.

5 Conclusion

5.1 The delivery of CIPs and the settlement of contract issues that date back to 2013/14 have ensured the delivery of the Trusts published forecast.

5.2 The over delivery of CIPs and productive negotiations with commissioners was expect to provide the Trust with the financial headroom to deal with the normal year end increases in costs. However with 6% of beds filled with Delayed Discharges of Care patients which are in turn contributing towards record sustained levels of bed occupancy along with an increasing trend towards a higher proportion of over 75 year old patients or patients needing special levels of nursing has meant the trust has had to apply flexibility to deliver a small surplus at year end.

Given the trend levels of spend in temporary staffing a review of the process around the need and costs of these staffing resources should be undertaken.

5.3 The Finance Committee are requested note this report and its report of meeting the break even duty for 2014/15.

Maidstone and Tunbridge Wells NHS Trust

Finance Pack

M12 - March 2015

March 2015

Maidstone and Tunbridge Wells NHS Trust

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Key Performance Indicators as at Month 12 2014/15

(A) TDA Accountability Framework and
(B) Monitor Continuity of Service Metrics

Maidstone and Tunbridge Wells NHS Trust

Key Metrics	Current Month Metrics			
(A) Accountability Framework	**Plan** (mc 01) **£000s**	**Actual / Forecast** (mc 02) **£000s**	**Variance** (mc 03) **£000s**	**RAG Rating** (mc 04)
NHS Financial Performance				
1a) Forecast Outturn, Compared to Plan	(12,301)	163	12,464	GREEN
1b) Year to Date, Actual compared to Plan	(12,301)	163	12,464	GREEN
Financial Efficiency				
2a) Actual Efficiency recurring/non-recurring compared to plan - Year to date actual compared to plan				AMBER
- Total Efficiencies for Year to Date compared to Plan	22,400	23,795	1,395	
- Recurrent Efficiencies for Year to Date compared to Plan	17,385	14,868	(2,517)	
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				RED
- Total Efficiencies for Forecast Outturn compared to Plan	22,400	23,795	1,395	
- Recurrent Efficiencies for Forecast Outturn compared to Plan	22,400	17,672	(4,728)	
Underlying Revenue Position				
3) Forecast Underlying surplus / (deficit) compared to Plan	(16,254)	(20,739)	(4,485)	RED
Cash and Capital				
4) Forecast Year End Charge to Capital Resource Limit	13,386	13,386	0	GREEN
5) Permanent PDC accessed for liquidity purposes		0		GREEN
Trust Overall RAG Rating				AMBER
(B) Continuity of Service Risk Ratings				
Year to Date Rating	2.50	2.50	0.00	GREEN
Fotecast Outturn Rating	2.00	2.50	0.50	GREEN

RAG STATUS		
Red	Amber	Green
A deficit position or 20% worse than plan	A position between 5% - 20% worse than plan	Within 5% or better than plan
20% worse than plan	A position between 10% - 20% worse than plan	Within 10% or better than plan
if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
20% worse than plan	A position between 10% - 20% worse than plan	Within 10% or exceeding plan
either greater than plan or 20% lower than plan	between 10% - 20% lower than plan	Within 10% of plan
PDC accessed	Not applicable	PDC not accessed
If forecast deficit position or if three or more RED in other metrics	If one or two RED or three AMBER	No RED and less than two AMBER
If score is 2.5 or lower	Not applicable	Score of over 2.5
If score is 2.5 or lower	Not applicable	Score of over 2.5

Statement of Comprehensive Income : as at Month 12 2014/15

Maidstone and Tunbridge Wells NHS Trust

Subject to audit

	Month 12 2014/15			Year End			
	Budget	Actual	Variance	Budget	Actual	Variance	Comments on variance in month and YTD
	£'000	£'000	£'000	£'000	£'000	£'000	
NHS Clinical Income							
Day Cases	2,903	3,444	541	35,010	34,163	(847)	Gen Surg, T&O, Gastro and Interventional Radiology were all ahead of plan in the month with T&O (£-1.2m) being the single largest adverse variance for the whole year.
Elective	2,250	2,271	21	28,634	23,247	(5,388)	Elective income largely on +trend in M12 . The trend includes outsourcing M1-6 to meet 18 weeks offset by underspend on Purchase of healthcare non NHS
Non Elective	7,443	8,435	992	87,636	92,075	4,440	G Med and A&E admissions ahead of plan in March and for the whole year (Gmed +£2.5m and A&E £1.9m).
Non Elective Cap	(334)	(1,401)	(1,066)	(3,937)	(7,811)	(3,874)	Any emergency income over £5.1m per month paid at 30% of tariff, this figure equates to the value of the 70% discount. Highest levels of NEL activity since July.
Outpatients New	1,906	2,036	130	22,217	23,811	1,594	Outpatient activity performance against plan influenced by Oncology and Diagnostics.
Outpatients Follow Up	2,406	2,612	207	27,696	29,890	2,194	
Outpatients Unbundled Imaging	715	839	124	8,226	9,141	915	
Unbundled Imaging Threshold	(172)	372	544	(1,978)	(1,434)	544	
Direct Access, A&E, Other Direct	5,740	5,199	(541)	66,906	60,500	(6,406)	A&E over £0.5m over for year but on plan in m12. Radiotherapy -£2.5m behind plan for year and -£0.2m for m12. Regular attenders behind plan for m12 and whole year (full year Onc -£2.6m and Haem -£2.0m).
Maternity Pathway	977	929	(48)	11,505	11,033	(472)	
Other NHS Clinical Income	1,346	4,580	3,234	13,585	39,047	25,462	In March contract settlements worth £1.7m and £1m of support funding all above plan. The full year variance includes £12m of support funding, £11.6m of cancer tariff benefits and £1.3m of 14/15 contract settlements.
Challenges	(614)	(756)	(142)	(7,067)	(6,962)	105	
NHD Support	1,333	1,138	(195)	16,300	16,300	0	
Income from Activities - HCDs	1,591	2,239	648	19,593	21,035	1,442	Driven by Cancer activity, charged as pass through so no direct benefit to bottom line.
Income from Activities - Other	590	668	78	6,638	7,102	464	
Sub Total NHS Clinical Income	**28,080**	**32,606**	**4,526**	**330,964**	**351,136**	**20,172**	
Non NHS Clinical Income							
Private Patients	743	905	161	8,594	6,922	(1,672)	
Injury Cost Recovery	80	137	57	962	1,224	262	
Other Non NHS for Patient Care	8	21	14	93	153	60	
Sub Total non NHS Clinical Income	**831**	**1,063**	**232**	**9,649**	**8,300**	**(1,349)**	
Non Clinical Income							
Education Training & Research	884	1,120	235	10,636	11,077	441	
Non Patient Services	1,096	1,578	483	13,183	13,787	604	
Commercial - Car Parking	182	225	43	2,184	2,185	0	
Commercial - Catering	109	99	(9)	1,303	1,273	(30)	
Commercial - Accommodation	47	41	(5)	559	478	(81)	
Donated Asset Income	140	433	293	150	455	305	
Government Grant Income	0	0	0	0	122	122	
All Other Income	982	2,330	1,348	11,711	14,434	2,723	
Sub Total Non Clinical Income	**3,439**	**5,827**	**2,388**	**39,727**	**43,811**	**4,084**	
Total Income	**32,351**	**39,496**	**7,145**	**380,341**	**403,247**	**22,906**	

Statement of Comprehensive Income : as at Month 12 2014/15

Maidstone and Tunbridge Wells NHS Trust

Subject to audit

	Month 12 2014/15			Year End			
	Budget	**Actual**	**Variance**	**Budget**	**Actual**	**Variance**	**Comments on variance in month and YTD**
OperatingExpenditure							
Pay Costs							
Medical							
Consultants	(2,632)	(2,646)	(14)	(31,714)	(30,609)	1,105	
Other Medical Grades	(2,385)	(2,032)	353	(28,488)	(26,602)	1,886	
Medical Locums	(194)	(675)	(481)	(3,179)	(7,242)	(4,062)	
Medical Agency	(76)	(304)	(228)	(1,189)	(2,970)	(1,781)	
Sub Total Medical Staff	**(5,287)**	**(5,656)**	**(369)**	**(64,570)**	**(67,423)**	**(2,853)**	Pay arrears and high cost temporary staffing to deal with staff absences.
Nursing							
Nurses Substantive - Trained	(5,232)	(4,775)	457	(61,168)	(57,064)	4,105	
Nurses Substantive - Untrained	(1,065)	(992)	73	(12,149)	(11,594)	555	
Nurse Bank	(290)	(782)	(492)	(4,978)	(8,755)	(3,777)	
Nurse Agency	(101)	(744)	(643)	(1,640)	(5,853)	(4,213)	
Sub Total Nursing	**(6,689)**	**(7,293)**	**(605)**	**(79,936)**	**(83,266)**	**(3,330)**	Although escalation beds dropped by the end of the month the number of occupied beddays was high in March. The bed occupancy was in part caused by DOTC patients who were occupying 6% of the Trust's beds.
Scientific, Therapeutic & Technical Staff							
STT Substantive	(2,883)	(2,791)	93	(33,850)	(32,610)	1,240	
STT Bank	(68)	(42)	27	(863)	(334)	529	
STT Agency	(188)	(327)	(139)	(2,293)	(2,689)	(396)	
Sub Total STT Staff	**(3,140)**	**(3,160)**	**(20)**	**(37,006)**	**(35,633)**	**1,373**	Vacancies in Cancer & Diagnostics continuing to cause underspends.
Admin & Senior Managers							
A&C/Sen Man Substantive	(2,963)	(3,705)	(742)	(35,496)	(34,759)	737	
A&C/Sen Man Bank	(136)	(115)	21	(1,708)	(1,046)	662	
A&C/Sen Man Agency	(11)	(184)	(173)	(129)	(1,585)	(1,455)	
Sub Total A&C/Sen Man Staff	**(3,110)**	**(4,004)**	**(894)**	**(37,333)**	**(37,390)**	**(56)**	In March a £0.85m provision against the possible HIS redundancies was made.
Support Staff							
Support Substantive	(1,077)	(964)	112	(12,928)	(12,208)	720	
Support Bank	0	(16)	(16)	0	(167)	(167)	
Support Agency	(1)	(144)	(142)	(17)	(666)	(649)	
Sub Total Support Staff	**(1,078)**	**(1,124)**	**(46)**	**(12,945)**	**(13,041)**	**(96)**	
Total Pay Costs	**(19,303)**	**(21,237)**	**(1,934)**	**(231,790)**	**(236,753)**	**(4,963)**	

Statement of Comprehensive Income : as at Month 12 2014/15

Maidstone and Tunbridge Wells NHS Trust

Subject to audit

	Month 12 2014/15			Year End			
	Budget	Actual	Variance	Budget	Actual	Variance	Comments on variance in month and YTD
Non Pay Costs							
Drugs & Medical Gases	(2,993)	(3,417)	(425)	(35,890)	(36,964)	(1,074)	Driven by Cancer activity driven HCD spend offset by recharged HCD to SCG/NHS England.
Blood	(206)	(193)	14	(2,192)	(2,091)	102	
Supplies & Services - Clinical	(2,665)	(2,963)	(298)	(31,740)	(33,100)	(1,360)	YTD driven by Pathology consumables, M12 adverse to plan because of £0.2m year end stock adjustment and higher than planned spend £0.1m on Paediatric rechargable devices.
Supplies & Services - General	(438)	(598)	(160)	(5,330)	(5,883)	(553)	Cleaning and Catering consumables and equipment.
Services from Other NHS Bodies	(526)	(222)	305	(5,561)	(5,406)	155	March favourable variance caused by reallocation of costs to Purchase of healthcare heading for outsourced pathology costs.
Purchase of healthcare from non NHS	(264)	(1,126)	(861)	(6,331)	(4,819)	1,512	Ongoing outsourcing of activity in T&O, Surgery, Cardiology and women's specialties.
Clinical Negligence	(891)	(891)	(0)	(10,692)	(10,692)	0	
Establishment	(324)	(397)	(73)	(3,900)	(3,992)	(92)	Nursing recruitment campaign costs in M9
Premises	(1,796)	(1,837)	(41)	(20,584)	(20,258)	325	In month variance as a result of recognising disputed Novell dispute over licences.
Transport	(105)	(189)	(84)	(1,595)	(2,150)	(555)	The bus service the Trust had to provide as part of the PFI development was planned to stop when the funding of £2.1m ran out (Sept 14). However the service has been extended until Jan 2015. Tier 1 ambulance service costs reduced in M1. Transport costs incurred linked to operational resilience have originally incurred in M10 have continued to be incurred
Other Non Pay Costs	(428)	(556)	(128)	(4,561)	(5,819)	(1,257)	Overspends on consultancy and legal costs.
Total Non Pay Costs	**(10,637)**	**(12,388)**	**(1,751)**	**(128,378)**	**(131,175)**	**(2,797)**	
Total Operating Expenses	**(29,940)**	**(33,626)**	**(3,685)**	**(360,168)**	**(367,928)**	**(7,760)**	
Reserves	1,072	0	(1,072)	4,546	0	(4,546)	
EBITDA	**3,482**	**5,870**	**2,389**	**24,718**	**35,319**	**10,601**	
Profit/Loss on Disposal	0	(48)	(48)	0	(50)	(50)	
Depreciation	(1,522)	(1,134)	389	(18,268)	(16,696)	1,571	revised Depreciation based on capital programme review and expected impairment
Impairment of Fixed Assets	0	(13,389)	(13,389)	0	(14,251)	(14,251)	Impairment assumption (also in technical adjustments)
Interest Receivable	2	11	8	26	48	22	
Interest Payable	(55)	(36)	18	(655)	(655)	0	
Other Finance Costs	(1,149)	(1,142)	7	(13,791)	(13,783)	8	
Public Dividends Payable	(535)	(331)	204	(6,420)	(4,887)	1,533	PDC per latest year end position work.
Other Finance Costs Total	**(3,259)**	**(16,068)**	**(12,809)**	**(39,107)**	**(50,274)**	**(11,167)**	
Surplus/(Deficit)	**223**	**(10,198)**	**(10,421)**	**(14,389)**	**(14,955)**	**(566)**	
Technical Adjustments to Surplus/(Deficit)	45	12,925	12,880	(13,791)	15,118	28,908	
Surplus/(Deficit) Compared to B/E Duty	**268**	**2,727**	**2,459**	**(28,179)**	**163**	**28,342**	
EBITDA Margin Calculation	**10.76%**	**10.76%**		**10.76%**	**10.76%**		

The forecast includes the notification of an additional £12m income for deficit support funding

SLA Position as at Month 12 2014/15

Maidstone and Tunbridge Wells NHS Trust

The year to date month 12 SLA position against the Trusts internal plan

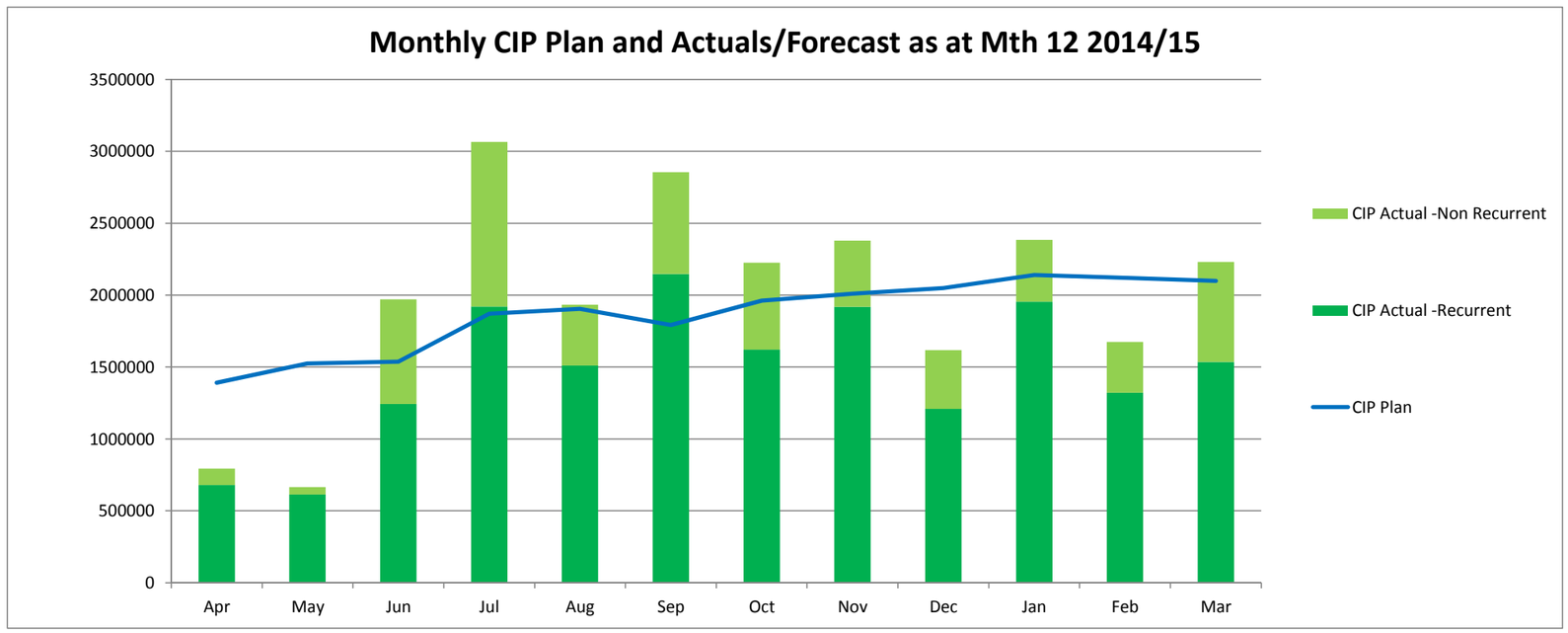
	Annual Plan	Phased plan (Month 12)	YTD Performance (Month 12)	Variance	% age Variance	FOT	FOT Variance	FOT % age Variance
	£'000	£'000	£'000	£'000	%	£'000	£'000	%
Daycase	35,010	35,010	34,163	-847	-2%	34,163	-847	-2%
Elective IP (in Excess days)	28,634	28,634	23,247	-5,388	-19%	23,247	-5,388	-19%
Non Elective IP (inc Excess days)	87,636	87,636	92,075	4,440	5%	92,075	4,440	5%
Non Elective Threshold	-3,937	-3,937	-7,811	-3,874	98%	-7,811	-3,874	98%
Outpatient New	22,217	22,217	23,811	1,594	7%	23,811	1,594	7%
Outpatient Follow up	27,696	27,696	29,890	2,194	8%	29,890	2,194	8%
Outpatient Unbundled imaging	8,226	8,226	9,141	915	11%	9,141	915	11%
Unbundled Imaging Threshold	-1,978	-1,978	-1,434	544	-27%	-1,434	544	-27%
Direct Access, A&E, other Direct	66,906	66,906	60,500	-6,406	-10%	60,500	-6,406	-10%
Maternity Pathway	11,505	11,505	11,033	-472	-4%	11,033	-472	-4%
Other NHS Clinical Income	5,058	5,058	16,106	11,048	218%	16,106	11,048	218%
CQUIN	5,557	5,557	5,190	-366	-7%	5,190	-366	-7%
CCG Reinvestment	2,970	2,970	0	-2,970	-100%	0	-2,970	-100%
Transitional support - Cancer	0	0	5,750	5,750	0%	5,750	5,750	0%
Challenge provision	-7,067	-7,067	-6,962	105	-1%	-6,962	105	-1%
NHD Support	16,300	16,300	16,300	0	0%	16,300	0	0%
NR deficit funding	0	0	12,000	12,000	0%	12,000	12,000	0%
Cost of Change	0	0	0	0	0%	0	0	0%
Total	**304,734**	**304,734**	**322,999**	**18,266**	**6%**	**322,999**	**18,266**	**6%**
Income from Activities - HCDs	19,593	19,593	21,035	1,442	7%			
Income from Activities - Other	6,638	6,638	7,102	464	7%			
Sub Total NHS Clinical Income (SOCI)	**330,964**	**330,964**	**351,136**	**20,172**	**6%**			

CIP Summary & Graph: as at Month 12 2014/15

Maidstone and Tunbridge Wells NHS Trust

WORKSTREAMS BY DIRECTORATE BUDGET		Year To Date Plan £'000	Year To Date Actual £'000	Year To Date Variance £'000	Forecast Plan £'000	Forecast Actual £'000	Forecast Variance £'000
Back Office	Paul Bentley	4,234	3,816	(418)	4,234	3,816	(418)
Corporate (PPU)	Angela Gallagher	385	260	(125)	385	260	(125)
Surgery	Simon Bailey	1,804	3,038	1,234	1,804	3,038	1,234
Surgery (Head & Neck)	Simon Bailey	979	1,468	489	979	1,468	489
Emergency & Medical Services	Akbar Sorma	5,592	2,453	(3,139)	5,592	2,453	(3,139)
Diagnostics & Therapies	Sarah Mumford	2,306	2,130	(176)	2,306	2,130	(176)
T&O	Guy Slater	1,160	638	(522)	1,160	638	(522)
Women's & Sexual Health	M.Wilcox	1,687	1,066	(621)	1,687	1,066	(621)
Paediatrics	Hamudi Kisat	841	382	(459)	841	382	(459)
Critical Care	Richard Leech	2,690	1,960	(730)	2,690	1,960	(730)
Cancer	Sharon Beesley	2,068	2,190	122	2,068	2,190	122
Corporate Finance		0	4,394	4,394	0	4,394	4,394
Overprogramme		(1,346)	0	1,346	(1,346)	0	1,346
Total By Directorate (includes all workstreams)		**22,400**	**23,795**	**1,395**	**22,400**	**23,795**	**1,395**

Recurrent v Non Recurrent Analysis	YTD £'000	FOT £'000
Recurrent	14,868	17,672
Non Recurrent	8,927	6,123
Total	**23,795**	**23,795**



Directorate Summary : Year to Date Position as at Month 12

Maidstone and Tunbridge Wells NHS Trust

Subject to audit

Directorates	SLA Income Budget £'000s	SLA Income Actuals £'000s	SLA Income Variance £'000s	Other Income Budget £'000s	Other Income Actuals £'000s	Other Income Variance £'000s	Expenditure Budget £'000s	Expenditure Actuals £'000s	Expenditure Variance £'000s	Net Contribution FOT Budget £'000s	Net Contribution FOT Actuals £'000s	Net Contribution FOT Variance £'000s	
Clinical Directorates													
Surgery	62,427	63,304	878	8,537	8,816	279	(41,064)	(41,528)	(464)	29,900	30,593	693	£0.6m plan shortfall on both income and expenditure for non delivery of IS work. Improved coding and activity growth driving income variances. Established staff shortages from vacancies and service changes covered by interims and CIP shortfalls driving adverse expenditure performance.
T&O	32,694	28,395	(4,299)	1,197	1,161	(36)	(17,851)	(16,310)	1,542	16,039	13,246	(2,793)	£1.9m plan shortfall on both income and expenditure for non delivery of IS work. Capacity pressures causing activity shortfalls generating remaining adverse income variances. 23% nurse vacancies and Junior Doc rebanding driving cost pressures.
Critical Care	9,343	8,910	(433)	2,034	1,991	(43)	(33,064)	(34,423)	(1,359)	(21,687)	(23,522)	(1,835)	Activity reductions due to changes in service and staff vacancies driving income shortfall. CIP shortfall £0.8m and £0.4m of new cost pressures generating adverse expenditure position.
Emergency & Medical Services	86,267	89,234	2,966	6,931	10,175	3,244	(68,588)	(78,318)	(9,731)	24,610	21,090	(3,520)	Non Elective income including A&E over performed against the annual plan by £3.5m (+6%)with Elective income including outpatients under performing against the annual plan by £0.5m (-3%). Pay overspent plan by £4.6m for the year (+9%)and non pay £2m (+9%). Temporary staff costs being the most significant drivers.
Cancer & Haematology	36,006	37,288	1,283	21,279	20,962	(317)	(39,367)	(39,906)	(540)	17,918	18,344	426	Activity variances in OP FU's, Radiotherapy and Chemotherapy driving the SLA over performance. PP income shortfalls £0.2m impacting other income. Activity driven variances on drugs and diagnostics driving the cost overspend.
Diagnostics, Therapies & Pharmacy Services	14,979	16,105	1,126	9,663	9,731	68	(32,568)	(33,106)	(537)	(7,926)	(7,269)	657	Activity driven favourable income variance offset by activity driven cost pressures. £0.9m of Vacancies for Scientific and Technical staff.
Obstetrics, Gynaecology & Sexual Health	30,953	30,612	(342)	701	709	9	(21,055)	(22,526)	(1,470)	10,599	8,795	(1,803)	
Paediatrics	10,054	10,701	648	828	824	(4)	(10,390)	(10,991)	(601)	492	534	42	
MTW-Healthcare	1,409	2,602	1,194	3,605	2,590	(1,015)	(4,472)	(4,464)	8	542	729	186	
Total Clinical Directorates	**284,131**	**287,152**	**3,021**	**54,775**	**56,960**	**2,185**	**(268,419)**	**(281,572)**	**(13,153)**	**70,487**	**62,541**	**(7,947)**	
Total Corporate Directorates				**9,334**	**9,547**	**213**	**(76,808)**	**(79,552)**	**(2,744)**	**(67,474)**	**(70,005)**	**(2,531)**	
Non Directorate	20,602	35,847	15,245	1,697	2,656	959	(37,615)	(30,854)	6,761	(15,316)	7,649	22,965	Reserves £6.3m and £11m deficit support funding
HIS				9,801	11,084	1,283	(9,801)	(11,105)	(1,304)	0	(21)	(21)	
Total Trust	**304,734**	**322,999**	**18,266**	**75,607**	**80,247**	**4,640**	**(392,644)**	**(403,084)**	**(10,440)**	**(12,303)**	**163**	**12,466**	

Maidstone and Tunbridge Wells NHS Trust

Statement of Financial Position

The Trust Balance Sheet is produced on a monthly basis and reflects changes in the asset values, as well as movement in liabilities.

£m's	Month - March Reported	Plan	Variance	February Reported
Property, Plant and Equipment (Fixed Assets)	371.8	396.6	(24.8)	380.1
Intangibles	2.4	1.3	1.1	2.2
PFI Lifecycle	0.1	0.0	0.1	0.2
Debtors Long Term	1.2	1.1	0.1	0.1
Total Non-Current Assets	**375.5**	**399.0**	**(23.5)**	**382.6**
Current Assets				
Inventory (Stock)	6.5	6.2	0.3	7.2
Receivables (Debtors) - NHS	23.8	29.5	(5.7)	48.1
Receivables (Debtors) - Non-NHS	9.6	7.4	2.2	12.2
Cash	3.8	0.9	2.9	9.1
Assets Held For Sale	0.0	0.0	0.0	0.0
Total Current Assets	**43.7**	**44.0**	**(0.3)**	**76.6**
Current Liabilities				
Payables (Creditors) - NHS	(2.9)	(5.3)	2.4	(3.1)
Payables (Creditors) - Non-NHS	(30.0)	(25.9)	(4.1)	(56.6)
Capital & Working Capital Loan	(2.2)	(2.2)	0.0	(2.2)
Temporary Borrowing	0.0	0.0	0.0	0.0
Borrowings - PFI	(4.8)	(4.8)	0.0	(4.8)
Provisions for Liabilities and Charges	(2.1)	(1.4)	(0.7)	(1.9)
Total Current Liabilities	(42.0)	(39.6)	(2.4)	(68.6)
Net Current Assets	**1.7**	**4.4**	**(2.7)**	**8.0**
Finance Lease - Non- Current	(208.0)	(208.0)	0.0	(208.8)
Capital Loan - (interest Bearing Borrowings)	(16.7)	(16.7)	0.0	(17.8)
Working Capital loan	0.0	0.0	0.0	0.0
Provisions for Liabilities and Charges	(2.3)	(2.2)	(0.1)	(1.4)
Total Assets Employed	**150.2**	**176.5**	**(26.3)**	**162.6**
Financed By:				
Capital & Reserves				
Public dividend capital	(199.5)	(217.3)	17.8	(198.7)
Revaluation reserve	(62.7)	(70.6)	7.9	(63.1)
Retained Earnings Reserve	112.0	111.4	0.6	99.2
Total Capital & Reserves	**(150.2)**	**(176.5)**	**26.3**	**(162.6)**

Key Observations relating to the year to date position

PPE - At the year end the depreciation charge was (£16.7m) and the in year capital spend was £14m, this includes donated £0.5m. This was £4.8m less than the planned expenditure of £18.8m based on the original plan.

NHS Receivables have reduced since the February position by £24.3m The total NHS invoiced debt at year end was £22.5m, this has decreased from the reported mth 11 position of £36.5m. Specialist Commissioning paid circa £5m at the start of April as part of the 14/15 year end negiotiations.

Trade receivable have decreased since month 11, Invoice Trade debtors have increased by £0.3m to £1.1m with the majority of debt relating to Charitable £0.4m, Corporate Organisations £0.3m and private health care £0.1m (pre September 2014). Compucare Private Patient aged debt balance is £2.2m.

The cash balance at 31st March is £3.8m. The Trust received circa £2.5m from Health Education relating to 15/16 Quarter 1 income, as this income was received early the Trust was able to carry this balance forward into 15/16, along with the planned closing cash balance circa £1m. The Trust released payments to suppliers and paid March TAX and NI in March.

NHS Payables have reduced from the month 11 position by £0.2m to £2.9m, of this balance £3.1m relates to registered invoices and (£0.2m) creditor accruals.

Trade Payables have reduced from the month 11 position by £26.6m, primarily due to the release of payments to suppliers. Included within the £30m reported trade payables figure are, invoiced trade creditors £11.6m, Pension £3m, £4.6m deferred income and £10.8m accruals.

The Trust is forecasting a pre-technical deficit of £14.9m, this includes £14.2m impairment in PPE and the £12m deficit support.

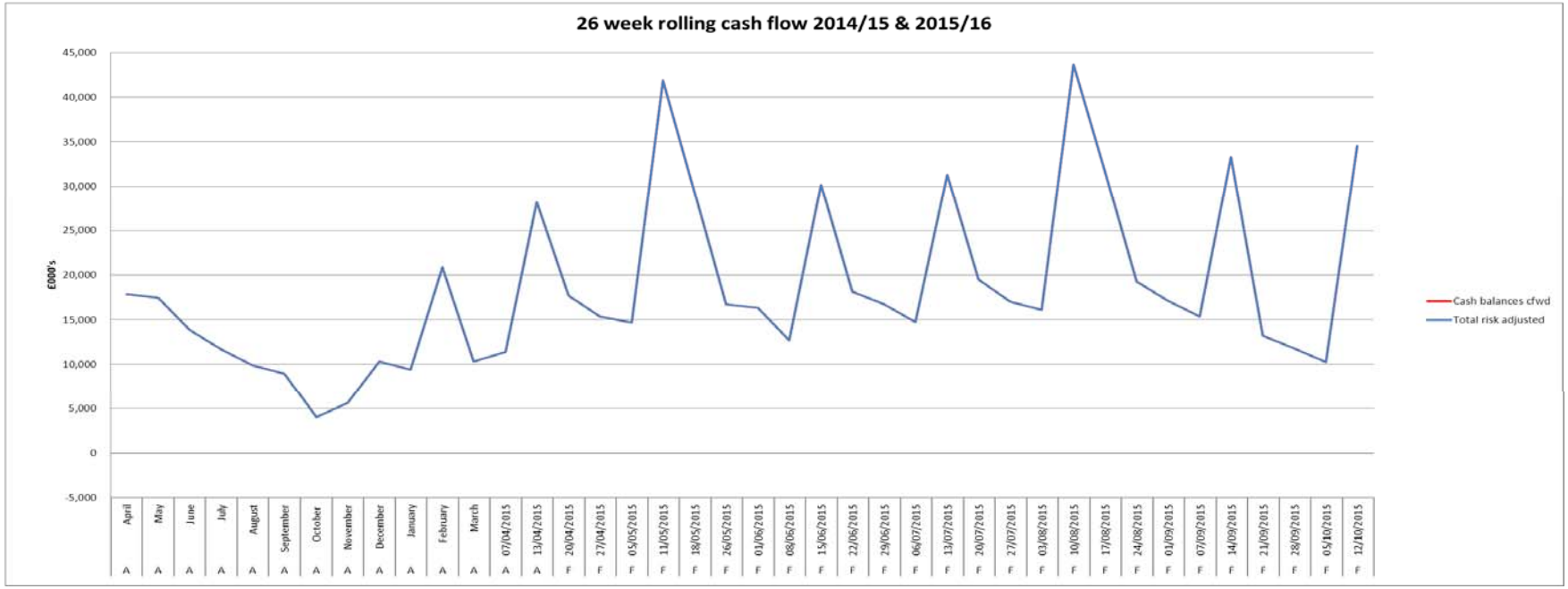
Key Actions

Focus on reducing debtor and creditor balances over 90 days and resolving queries as they arise. Ensure that invoices are raised promptly and not recurring accrual entries.

Cash is managed and updated on a daily basis and reported in the weekly flash report

Maidstone and Tunbridge Wells NHS Trust

26 Week graphical presentation of cash balances up to w/c 12th October 2015, actuals at 16th April 2015



	A	A	A	A	A	A	A	A	A	A	A	A	A	A	F	F	F	F	F	F	F
Week commencing	April	May	June	July	August	September	October	November	December	January	February	March	07/04/2015	13/04/2015	20/04/2015	27/04/2015	05/05/2015	11/05/2015	18/05/2015	26/05/2015	01/06/2015
Cash balances cfwd	**17,839**	**17,445**	**13,852**	**11,677**	**9,869**	**8,953**	**4,009**	**5,619**	**10,293**	**9,392**	**20,839**	**10,334**	**11,390**	**28,185**	**17,688**	**15,390**	**14,667**	**41,852**	**29,229**	**16,743**	**16,320**
Debtors carry forward into 15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15/16 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - Revenu	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total risk adjusted	**17,839**	**17,445**	**13,852**	**11,677**	**9,869**	**8,953**	**4,009**	**5,619**	**10,293**	**9,392**	**20,839**	**10,334**	**11,390**	**28,185**	**17,688**	**15,390**	**14,667**	**41,852**	**29,229**	**16,743**	**16,320**

	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Week commencing	26/05/2015	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	20/07/2015	27/07/2015	03/08/2015	10/08/2015	17/08/2015	24/08/2015	01/09/2015	07/09/2015	14/09/2015	21/09/2015	28/09/2015	05/10/2015	12/10/2015
Cash balances cfwd	**16,743**	**16,320**	**12,689**	**30,162**	**18,150**	**16,752**	**14,729**	**31,314**	**19,503**	**17,005**	**16,082**	**43,700**	**31,744**	**19,258**	**17,133**	**15,386**	**33,301**	**13,215**	**11,792**	**10,269**	**34,526**
Debtors carry forward in 15/1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15/16 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - Revenu	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total risk adjusted	**16,743**	**16,320**	**12,689**	**30,162**	**18,150**	**16,752**	**14,729**	**31,314**	**19,503**	**17,005**	**16,082**	**43,700**	**31,744**	**19,258**	**17,133**	**15,386**	**33,301**	**13,215**	**11,792**	**10,269**	**34,526**

NHS Commercial In Confidence

Capital Financial Status Report to 31st March 2015

Maidstone and Tunbridge Wells NHS Trust

	£000's	£000's	£000's	£000's	£000's		
Capital Projects/Schemes	**Original TDA Capital Plan**	**Adjusted Capital Plan**	**Forecast Outturn Spend**	**Committed Spend**	**YTD actual Spend**	**% of YTD spend against FOT spend**	**Narrative**
Estates	7,162	4,096	3,963	4,013	3,963	**100.0%**	
PFI Lifecylcle payment	89	145	145	145	145	**100.0%**	
ICT	6,136	4,473	5,067	5,067	5,067	**100.0%**	ICT funding for Nurse Tech funding confirmed as £670,343.
Equipment (excluding Donated)	5,298	4,728	4,253	4,253	4,253	**100.0%**	
Total	**18,685**	**13,442**	**13,428**	**13,478**	**13,428**	**100.0%**	
Outturn suplus/(shortfall)			**14**				

Capital Projects/Schemes	**Adjusted Capital Plan**	**Forecast Spend**	**Committed Spend**	**YTD actual Spend**	**% YTD spend v FOT spend**	**Narrative**
Estates Schemes						
- Ward Reconfigurations & other renewals	1,992	1,906	1,956	1,906	100.0%	Includes developments for AAU at TWH, Whatman, MOU, Admissions at Maidstone
- Backlog Maintenance	1,136	1,171	1,171	1,171	100.0%	
- TWH Staff Accommodation (32 High St)	568	586	586	586	100.0%	
- KPP	400	299	299	299	100.0%	
Estates Total	**4,096**	**3,963**	**4,013**	**3,963**	**100.0%**	
PFI Lifecylcle payment	**145**	**145**	**145**	**145**	**100.0%**	
ICT Schemes						
- Infrastructure/Clinical/Non-clinical systems	1,803	2,530	2,530	2,530	100.0%	Includes Windows7 mirgration, additional & replacement devices and SACP. Additional funding has been agreed bringing forward approved projects from 15/16 to utilise slippage on other areas of the programme.
- KPP	365	348	348	348	100.0%	
- EDM (eNotes) - Safer Hospital Safer Wards Fund	425	426	426	426	100.0%	
- Chemo ePrescribing	1,210	889	889	889	100.0%	
- Nurse Technology Fund (Nerve Centre)	670	874	874	874	100.0%	£670k Nurse Tech Funding approved for 14/15. Trust has contributed additional funding.
ICT Total	**4,473**	**5,067**	**5,067**	**5,067**	**100.0%**	
Equipment Schemes						
- Linac 2 Replacement	2,638	2,702	2,702	2,702	100.0%	
- General Equipment (excluding Donated)	2,090	1,550	1,550	1,550	100.0%	
Equipment Total	**4,728**	**4,253**	**4,253**	**4,253**	**100.0%**	
TOTAL OF SCHEMES	**13,442**	**13,428**	**13,478**	**13,428**	**100.0%**	

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - April 2015

4-10 Breaking the Cycle Update — Chief Operating Officer

Summary / Key points

The aim of Breaking the Cycle initiatives is to rapidly improve patient flow to produce a step-change in performance, safety and patient experience. The initiative is typically run over one week during which the whole organisation and its health and social care partners focuses on improving the emergency care pathway.

NHS England sent out 'invitations' prior to Easter 2015 to strongly encourage local health economies experiencing challenges in meeting the A&E performance target of 95% in Q4 to undertake a 'Perfect Week Light' otherwise known as 'Breaking the Cycle' (BTC). The West Kent Systems Resilience Group collectively decided to run the BTC initiative from MTW during the period of 26 March – 02 April with all partners' full agreement and involvement. It was acknowledged that to reflect the current risk to patient flow it was sensible to focus the whole week on discharges and the discharge process – particularly patients with a delayed transfer of care [DTOC]. It was expected that the intense focus would help to create capacity and learning to support performance over the Easter period and beyond.

Which Committees have reviewed the information prior to Board submission?
Executive Team

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
For Information

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
NHS Trust

Breaking the Cycle Week

Thurs 26 March – Thurs 02 April 2015

1. Strategic Context

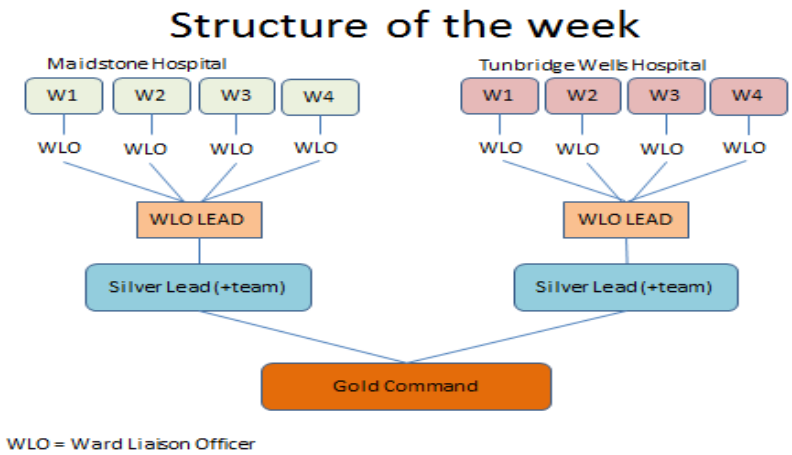
NHSE sent out 'invitations' prior to Easter 2015 to strongly encourage local health economies experiencing challenges in meeting the A&E performance target of 95% in Q4 to undertake a 'Perfect Week Light' otherwise known as 'Breaking the Cycle' (BTC). The West Kent Systems Resilience Group collectively decided to run the BTC initiative from MTW during the period of 26 March – 02 April with all partners' full agreement and involvement. It was acknowledged that due to the short timescale to implement this initiative the focus would be on discharges, with the view to create capacity and learning to support performance over the Easter period and beyond.

2. Background

The aim of *Breaking the Cycle* initiatives is to rapidly improve patient flow to produce a step-change in performance, safety and patient experience. The initiative is typically run over one week during which the whole organisation and its health and social care partners focuses on improving the emergency care pathway.

Clinicians who have implemented *Breaking the Cycle* initiatives have been struck by how directly both safety and quality link to good patient flow. This is about much more than delivering the 4-hour emergency department standard. Breaking the Cycle aims to embed the SAFER (Appendix 1) patient flow bundle; a set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. Routinely undertaking all the elements of the SAFER patient flow bundle we will improve the journey our patient's experience when they are admitted to our hospital.
The focus for the MTW week was on early discharges as outlined above and to complement the internal work at MTW which if focussed on all aspects of the patient flow bundle

3. Structure implemented



WLO = Ward Liaison Officer

4. Overview

There was a high level of engagement with the initiative across the trust and with our local health economy partners. Particularly successful was the role of the Ward liaison officers drawn from MTW and CCG staff. Their input was welcomed by the wards as it allowed clinical staff to focus on

patient care and also brought welcome challenge to some accepted norms. We are now considering how this role could be further developed within the ward establishments.
Overall the initiative was a success, in so far as it allowed whole health economy to recognise and take ownership of the challenges that the Trust faces in efforts to improve patient flow through the hospital. It also created an environment that enabled us to reflect on our internal systems & processes and how we could better engage our staff to improve these. The rest of the report focuses on the areas of potential improvement rather on things what went well.

5. Main themes (cross system)

- Reconciled Patient Target List [PTL] shared by health, social services and external agencies which identifies the patients requiring on-going care, their intended destination and the time between referral and transfer including a record of all events taking place to support the discharge. **Action MTW to address**
- More proactive forward planning for discharges by all partners
- Push/Pull: discharges are pushed by MTW but not pulled by KCC/KCHT
- System is risk averse to managing patients at home
- Management of whole system patient flow not joined up enough or synchronised to ensure patients care is coordinated and delivered in the most appropriate setting. - As part of the 20152/16 CQUIN A review will take place to assess the level of occupancy of patients who no longer have a need for an acute hospital bed.
- Current PTS contract does not reflect or support the operational needs of an acute service

6. Main themes (internal)

- Day before actions (including PTS) - Lack of transparent discharge management/patient flow system hinders effective monitoring of day before actions.
- Electronic Discharge Notes (EDNs) - New, clinically led working group established to improve the quality and timeliness of EDNs
- Inpatient therapies – There is some reluctactance to discharge patients to receive community based services – this needs to be explored.
- complicated internal pathways not clear to all teams (e.g. to Oncology)
- Clinical leadership and engagement – Events held/planned to increase clinical engagement but more needs to be done
- Access to diagnostics, ward staff too readily accept delays in Echo, Interventional radiology and MRI before escalating
- Delays in handovers from UMAU/MAU and in specialist reviews
- 7 day working not fully implemented in all key areas.

7. Main themes (external)

- Limited medical cover for community beds and Enhanced Rapid Response Service (KCHFT)
- Seven day working not implemented (KCHFT and KCC)
- Admission criteria to community services needs alignment to MFFD criteria (KCHFT)
- CHC assessment and placements not responsive 7/7 (WK CCG)
- Insufficient case management resource to meet the demand on the wards
- Insufficient access to packages of care & care home placements (KCC) – High numbers of patients that are medically fit for discharge occupy acute beds.
- Delay in providing enablement to patients
- Choice protocol not enforced robustly - One third of DToC related to patient or family choice because there is not enough capacity available to families, social care or community providers.
- Lack of “discharge to assess” model - This means patients on going care and therapy needs are assessed and provided in the community by a team consisting of nurses, Occupational Therapists (OT’s), Physiotherapists (PT’s) and rehabilitation assistants. Patients will no longer wait in hospital for these assessments, which reduces delayed

discharges and improves patient flow. The key challenge to implementation is the lack of capacity in community. This work will be led by KCC Social Services with significant input from MTW.

8. Next Steps

The System Resilience Group met on the 9th April, led by WKCCG and included CEO representation from all organisations. A commitment was given by all parties to address the DTOC problem and clear objectives were set in terms of

- Establish a patient tracking system
- Develop and alternative model to Romney Ward in West Kent
- Develop a discharge to assess model for patients requiring on-going care post acute admission.
- Revisit the issue through the system-wide review by the Emergency Care Intensive Support Team in June 2015.

The full action plan will be agreed with timescales through the SRG.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - April 2015

4-11 CQC Quality Improvement Plan Assurance Report — Chief Nurse

Summary / Key points

The enclosed report provides information on the progress being made against the delivery of the CQC Quality Improvement Plan. This is the first assurance report produced and will be produced monthly here on.

Overall good progress is being made against each of the compliance actions. There are some challenges (capacity issues and recruitment) that are impacting on the full delivery of some actions but sufficient mitigation is in place to ensure patient safety is maintained.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 15.04.15

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Assurance

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CQC Quality Improvement Plan

Assurance Report

This report is produced to provide staff, patients, stakeholders, the CQC and the board with an assurance against the Quality Improvement Plan developed and agreed in response the CQC inspection report that was published in February 2015. This is a monthly report, following which the main Quality Improvement Plan will be updated

The report will be submitted to the Trust Management Executive, the Trust Board, TDA and the CQC and will be shared with local commissioning groups. A summary will be published on the MTW intranet and MTW website.

Overview of progress to date

Enforcement action – Water testing Maidstone Hospital

The enforcement notice relating to annual water sampling for legionella was responded to immediately with actions undertaken to address the issue and ensure governance is now place to prevent the risk of re-occurrence. A full report has been submitted along with a request for the enforcement notice to be lifted. This evidence submitted is being reviewed by the CQC.

Compliance actions – Paediatrics

A validated paediatric early warning system has been identified and agreed for implementation at MTW. A paper version is expected to be printed and implemented imminently together with a revised escalation protocol. This will then be uploaded and used on NerveCentre (electronic observations) in the coming months.

The arrangements and management for the administration for topical anaesthetics have been revised ensuring that these are prescribed. The revised arrangements are being regularly audited to provide evidence.

A draft Standard Operating Procedure (SOP) has been developed between paediatrics and surgery to clarify clinical governance arrangements and management of surgical children on the paediatric ward. This is currently being consulted upon within both directorates prior to finalisation and implementation.

Compliance actions – Critical care

The Consultant rota has been reviewed and amended for improved intensivist cover of critical care at weekends in line with the core standards for critical care. Recruitment for additional Consultants to support the rota continues but is challenging and thus alternative cover arrangements with risk assessed mitigation is being worked through to further improve the situation of ward round cover on both sites at weekends.

A business case has been approved and there has been successful recruitment to the critical care outreach team. Further recruitment is underway to enable the service to be delivered 24 hours a day, 7 days a week as a new fully integrated model within critical care.

Privacy and dignity issues in intensive care have been addressed through improved bathroom facilities for patients. This work is nearly fully complete.

Compliance action – Contracted security staff training

There has been significant work in achieving the required standards of training for security staff to ensure they have the appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.

Governance framework

A comprehensive review of governance within MTW has commenced, along with work to improve reporting and learning from incidents through a single reporting system. This work will contribute to improved management of risks, enhanced patient safety and a system of clinical governance that is clear, consistent and effective.

Status of plan

KEY to progress rating (RAGB rating)

	Blue	Fully Assured
	Amber	More assurance required
	Green	Assured / in progress
	Red	Not assured

	Operational lead	Progress rating	Issues / Comments
Enforcement Notice	Jeanette Rooke Director of Estate & Facilities		Action completed and submitted to CQC for review
CA 1	Jenny Head Matron Children Services		None raised
CA 2	Daniel Gaughan General Manager, Critical Care		The full cover of intensivists simultaneously on both site at weekends will be implemented in September (needs final agreement and sign off from clinicians), which means the completion date for action 2 of the compliance action will be later than expected
CA 3	Daniel Gaughan General Manager, Critical Care		
CA 4	Jacqui Slingsby Matron, Critical Care		None raised
CA 5	Jacqui Slingsby Matron, Critical Care		None raised
CA 6	Jacqui Slingsby Matron, Critical Care		Concern in relation to patient flow at TWH which impedes patients having timely transfers.
CA 7	Siobhan Callanan Associate Director of Nursing		None raised
CA 8	Jacqui Slingsby Matron, Critical Care		Not yet fully accessible to all patients at present
CA 9	Richard Hayden Deputy Director of Workforce		None raised

	Operational lead	Progress rating	Issues / Comments
CA 10	Lynn Gray Associate Director of Nursing		Review of DSSA guidelines affecting options appraisal, financial and PFI constraints on estates work
CA 11	Wilson Bolsover Deputy Medical Director		None raised
CA 12	John Sinclair Head of Quality, Safety, Fire and Security		None raised
CA 13	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Patient safety team is recruiting of a 6 month secondment Patient Safety Manager who will help implement some of these required changes. Recruitment expected May / June 2015
CA 14	Hamudi Kisat / Johnathan Appleby Clinical Directors		None raised
CA 15	Karen Woods Risk and Governance Manager, Children and Women's Services		None raised
CA 16	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		None raised
CA 17	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		None raised
CA 18	Jenny Head Matron Children Services		None raised

Enforcement notice

		REF	Directorate	Issue Identified	Action /s	Lead	Date to be completed	Evidence Required	Outcome/success criteria
Executive Lead: Glenn Douglas	**Date compliance will be achieved by: January 2015**	**EN1**	Estates and Facilities Management	The annual water sampling for legionella was six months overdue at Maidstone Hospital	1. Internal Investigation undertaken 2. External review undertaken 3. Water Hygiene Management Action Plan developed and implemented 4. Governance around water hygiene management reviewed and new system of robust Governance implemented 5. Risk Assessments and Sampling testing undertaken 6. Authorised Engineer (Water) appointed 7. Estate Management and Audit review of processes with a number of new appointments have been made within the senior team of Estates Services ensuring Authorised Persons in each technical element. The planned preventative maintenance schedule is currently being reviewed to ensure all statutory requirements are incorporated. In addition a comprehensive schedule is being developed for audit purposes. The internal auditing will be triangulated by the inspections, risk assessments and annual report undertaken and issued by the Authorised Engineer (Water) who provides the independent assurance and validation.	Jeanette Rooke	Completed 14th January 2015	Report produced outlining Governance, testing results and audit processes External review report Certificates of sampling Ongoing Agenda and Minutes of meetings	Water hygiene Management is compliant with statutory requirements with robust governance and management in place

Report submitted with all actions completed RAGB status: GREEN

Compliance action 1				CA1
Issue: *The PEWS system had not been validated and was not supported by a robust escalation protocol that was fit for purpose and was not standardised across the children's' directorate*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Jenny Head, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. PEWS chart reviewed in line with tertiary referral centres (Nottingham) or PEWS from National Institute for Innovation (used in other Trusts)	Reviewed PEWS charts from Nottingham and National Institute for Innovation. The Paediatric Directorate have decided to use the Nottingham tool as the more comprehensive tool and it has been proven to work well within paediatric areas similar to MTW. Awaiting meeting with printer to get draft chart for MTW. Chart will then go to relevant committees for approval.	1. Validated PEWS in place. 2. Revised escalation protocol in place 3. Staff competent and consistent in using PEWS and escalation. 4. 3 monthly audit of compliance 5. Evidence of communicatio n via meetings	31/6/15	
2. Escalation protocol reviewed alongside the PEWS chart review	Revised escalation protocol disseminated to all staff and is in use in all paediatric areas			
3. Once agreed, PEWS chart and escalation protocol implemented across Children's services directorate via teaching sessions, ward level meetings, A&E and Children's services Clinical Governance meeting	Awaiting new PEWS charts to be approved and printed			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E	In consultation with Nervecentre and have agreed that electronic observations should be implemented after the new paper copy has been rolled out to staff and they are trained to use it. Currently in conversation with Nervecentre re the electronic process and escalation format for PEWS within MTW.	6. Compliance audit from Nervecenter	31/12/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): No evidence yet as waiting for meeting with printer to obtain draft charts				
Assurance statement :				
It has been identified that the introduction of a new PEWS chart to the wards must be done in a planned and controlled method. The trust is confident that in the interim, with the new escalation process in place, and the current PEWS tool, children who are at risk of deterioration are identified appropriately.				
Areas of concern for escalation:				
none				

Compliance action 2				CA2
Issue: *Contrary to the core standards of the Intensive Care Society: There was a lack of cover by consultants specialising in intensive care medicine at weekends; for example, one consultant covered more than 15 patients on two sites.*				
Lead: *Richard Leech, Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Morning week-end ward rounds on both units implemented	Implemented January 2015.	1. Anaesthetic electronic rota showing allocation of intensivists at weekends to site allocation 2. Business case including risk assessment, mitigations and staffing analysis against core standards 3. TME Meeting minutes where business case considered and decision made 4. Audit of patients medical notes documenting weekend Consultant reviews	1/2/15	
2. Second ward round at weekend is taking place at both units. Risk assessment undertaken with mitigations in place as required	Second ward round is taking place in person on one site and in person or by telephone the other site (dependent on acuity and dependency). Risk assessment completed, with key stakeholder for final sign off.		31/3/15	
3. The rota for the intensivists reviewed in line with the requirements of the ICS core standards	Rota group set up. Meeting booked April 2015 to finalise 1-8 option with block working. Plan to implement 1 in 8 rota September 2015 with internal locum cover.		31/3/15	
4. Business case for additional intensivists developed and considered	First draft completed and with stake holder for review, financial appraisal completed.		17/6/15	
5. Mitigation in place for non-compliance OR	Mitigation part of CQC intensivist risk assessment		30/6/15	
6. Recruitment achieved	Interview *2 intensivists 14-4-15		1/4/16	
Action Plan running to time: **Yes, for overall compliance**				
Evidence submitted to support update (list): Electronic rota				
Assurance statement :				
All actions progressing				
Areas of concern for escalation:				
The full cover of intensivists simultaneously on both site at weekends will be implemented in September (needs final agreement and sign off from clinicians), which means the completion date for action 2 will be later than expected				

Compliance action 3				CA3
Issue: *Contrary to the core standards of the Intensive Care Society: The consultant was not always available within 30 minutes. There was only one ward round per day when there should be two to comply with core standards.*				
Lead: *Richard Leech, Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Travel times & distance for each consultant being reviewed to assess compliance with 30 minutes availability for each individual consultant.	Clinical director has reviewed travel times. No incidents reported. Report from clinical director in progress	1. Report from Clinical Director outlining each Consultant's travel distance and confirmation of each Consultants ability to respond within 30 minutes. 2. Any delays in responding to be reported as incidents (DATIX) 3. Audit of patients medical notes documenting weekend Consultant reviews	31/5/15	
2. Risk assessment to be undertaken where travel times exceed 30mins	Part of CQC intensivist risk assessment (in draft at present). SOP to be developed in terms of 30 minute response time (target date Sept 2015)		31/5/15	
3. Ward round compliance actions in CA2	AS CA2. Shift leaders undertaking spot audits of morning ward rounds on both sites at weekends. Second ward round will be implemented in full in September		31/3/15	
Action Plan running to time:	**No, slight delay for action 3 (See CA2)**			
Evidence submitted to support update (list):				
Assurance statement :				
Actions progressing to time				
Areas of concern for escalation:				
The full cover of intensivists simultaneously on both site at weekends will be implemented in September (needs final agreement and sign off from clinicians), which means the completion date for action 3 will be later than expected				

Compliance action 4				CA4
Issue: *Contrary to the core standards of the Intensive Care Society: Admissions were delayed for more than four hours once the decision was made to admit a patient to ICU*				
Lead: *Richard Leech, Clinical Director*		**Operational Lead:** *Jackie Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Consider option of ring fencing ITU bed for admission	Discussed at Trust Management Executive (TME) 15/4/15	1. Minutes of TME meeting where ring fencing option discussed 2. SOP for ITU admissions, transfers and discharges. SOP for managing critically ill pt when ITU is full 3. Site report documentation 4. Monthly performance data 5. DATIX IR1 completed for each patient who has a delayed admission to ITU due to inability to move wardable patients. Investigation into each occurrence with clear lessons learnt and changes implemented	20/5/15	
2. Standard Operating Procedure developed relating to ITU admissions	Admissions policy and operational policy reviewed and comments made. To work content into SOP at next Senior team meeting w/c 27/4/15		31/5/15	
3. Review SOP for managing critically ill patients requiring ITU, when ITU capacity is full (for e.g. in recovery)	Some preliminary work and pathways completed last year revisited. For further input from Emergency Theatre recovery team		30/4/15	
4. ITU referrals & those patients requiring ITU will be identified and discussed at each site meeting and priorities escalated as appropriate.	Attendance at each site meeting by Shift leader/matron in place. ITU referrals should be consultant to consultant and raised to both the Clinical site team and Matron/Shift leader in ICU. Clinical priorities will be identified by the Consultant intensivist		1/4/15	
5. When no prospect of ITU capacity available on either site then arrangements for transfer to another unit will be made.	Consider escalation feasibility before any transfer. Critical care capacity within Trust reviewed before transfer outside of organisation. National Emergency bed service already in place.		1/1/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): none submitted				
Assurance statement :				
Actions progressing				
Areas of concern for escalation:				
None noted				

Compliance action 5				CA5
Issue: *Contrary to the core standards of the Intensive Care Society: Discharges from the ICU were delayed for up to a week. Of all discharges, 82% were delayed for more than 4 hours*				
Lead: *Richard Leech, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure to be developed relating to ITU discharges	SOP meeting planned end April	1. SOP for ITU admissions, transfers and discharges. 2. Site report documentation. 3. Monthly performance data 4. DATIX incident report completed for each patient who has a delayed discharge from ITU Investigation into each occurrence with clear lessons learnt and changes implemented	31/5/15	
2. Transfers out of ITU to be followed up on a named patient basis at each site meeting	This takes place but need to ensure consistency		1/4/15	
3. To link in with Trust wide work around patient flow and delayed discharges improvement plan developed in line with D16 CQUIN and in collaboration with Chief Operating Officer and Clinical Site Management team	Monthly delayed discharge performance data captured on performance dashboard and within monthly unit reports. Incident forms completed for each delay, clinical site team identified as handlers.		30/5/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): Daily site reports				
Assurance statement :				
Actions taking place with work ongoing				
Areas of concern for escalation:				
None noted				

Compliance action 6				CA6
Issue: *Contrary to the core standards of the Intensive Care Society: Overnight discharges take place from the ICU.*				
Lead: *Richard Leech, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. All ward fit patients to be identified to the site team at the earliest opportunity but by 1500 at the latest each day.	All patients deemed ward fit or likely to be fit are named at site meetings and entered on capacity handover form to the site team, together with any special requirements i.e. Side room needed, specialist ward etc.	1. Incident (DATIX) report to be raised on all post 20:00hrs transfers. Review and identification of where lessons can be learnt and improvements made	1/3/15	
2. Transfer plans to be agreed and completed by 20:00 hrs at the latest. No patients to be routinely transferred from ITU after 20:00.	Core standards state that no patient should be transferred from ITU after 22:00. Transfer delayed if bed not available until after the stated time, if critical care capacity allows. During March, 12 patients at TWH and 3 at Maidstone were transferred to wards between 22:00 and 07:00. Incident reports raised. Patients though deemed fit prior to these times were not able to be moved to a ward due to bed capacity issues.		1/3/15	
Action Plan running to time:		**Yes but delivery impacted by capacity challenges**		
Evidence submitted to support update (list): Daily site reports				
Assurance statement :				
Further work being undertaken with the clinical site team and discharge out of hours avoided unless a clinical emergency deems otherwise.				
Areas of concern for escalation:				
Concern in relation to patient flow at TWH which impedes patients having timely transfers.				

Compliance action 7				CA7
Issue: *The outreach service does not comply with current guidelines (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2011))*				
Lead: *Richard Leech, Clinical Director*		**Operational Lead:** *Siobhan Callanan, ADN planned care*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Business Case approved	Business Case signed off 29th January 2015	1. Rota showing 24 hour / 7day cover 2. Review of service and performance data via Directorate Clinical Governance meetings	27/1/15	
2. Recruitment to posts	Recruitment of Outreach nurses underway 3.53 wte have accepted posts 1.77wte still to recruit to.		1/9/15	
3. Implementation of a 24 hour 7 day out-reach service which will be fully integrated with critical care service	Consultation process commenced Draft paper to go out w/c 20th April		1/10/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Job descriptions for Critical Care Team Business case including attachment with costings Email confirming sign off Advert for Critical Care posts				
Assurance statement :				
We are on track to deliver the plan, with good engagement across the teams and the support of the executive team				
Areas of concern for escalation:				
No areas of concern at present				

Compliance action 8				CA8
Issue: *Improvements are needed in relation to the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients.*				
Lead: *Richard Leech, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Conversion of an existing toilet to a patient toilet & bathroom facility at Tunbridge Wells Hospital	Bathroom facility for patients has always been in place and contains a toilet within the shower room. The staff toilet which is co-located to the existing facility has been re-assigned and used as a patient toilet. Awaiting signage change.	1. Photo of Toilet / shower facilities appropriate for patient use 2. Confirmation at Executive / Non Executive walkabout	1/4/15	
2. Provision of appropriate patient washing facilities within Critical Care at Maidstone Hospital	Shower room available and two designated patient toilets, one which has disabled access; all in use. Awaiting new shower chair.		1/4/15	
Action Plan running to time:	**Yes**			
Evidence submitted to support update (list): Photographs: See attachment 1				
Assurance statement :				
Areas assigned and being used appropriately.				
Areas of concern for escalation:				
• Two signs and grab rail requested and awaiting fitting (Timeframe 2-3 weeks). • Waiting for new shower chair for Maidstone				

Compliance action 9				CA9
Issue: *The provider did not ensure that care and treatment was provided to service users with due regard to their cultural and linguistic background and any disability they may have*				
Lead: *Richard Hayden, Deputy Director Human Resources*		**Operational Lead:** *Richard Hayden, Deputy Director Human Resources*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Appoint a dedicated lead for Equality and Diversity for Trust		1. Substantive E&D Lead Appointed 2. Training records against E&D awareness programme 3. New E&D Strategy 4. Detailed action plan for improvements 5. Evaluation of changes to service and feedback from staff (staff survey), patients, Healthwatch and community groups (with actions developed and monitored as required)	1/9/15	
2. Develop an E&D awareness programme for all staff			1/10/15	
3. Review and develop new E&D strategy for organisation, in collaboration with MTW staff and partner organisations			1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff	All staff e-mail sent February 2015. Posters developed about current access to translation services and sent to ward areas for display in staff areas		1/2/15	
5. Identify an existing NHS centre of excellence and buddy with them to ensure best practice and learning implemented in a timely fashion			1/6/15	
6. Conduct a comprehensive review of all existing Trust practices in relation to E&D requirements - for example information, translation, clinical practices, food, facilities			1/4/16	
7. Develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch			1/10/15	
8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity			1/9/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Poster + e-mail				
Assurance statement :				
Longer term actions commenced, more to report next month				
Areas of concern for escalation:				
None to report				

Compliance action 10				CA10
Issue: *Dignity and privacy of patients was not being met in the Clinical Decisions Unit.*				
Lead: *Akbar Soorma, Clinical Director*		**Operational Lead:** *Lynn Gray, ADN emergency*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Options appraisal for addressing existing dignity and privacy issues in CDU (2 main options are Option 1: changing function of CDU or Option 2: provision of toilet facilities)	Options appraisal currently being developed to identify options to address privacy and dignity issues Meeting arranged with Estates Team to assist with development of proposals Report to Directorate Board	1. Options appraisal paper 2. Changes to CDU environment reviewed by link executives and reported at Standards Committee 3. Site report documentation	1/5/15	
2. Agree preferred option and implement	Report to Directorate Board		Option 1: 1/4/16 Option 2: 1/10/15	
3. Each patient to be tracked and discussed at each site meeting to ensure timeframes met and plan for discharge / transfer in place	Implemented at all site meetings and record of discussion to be recorded on site report documentation		1/4/15	
4. To link in with Trust wide work around patient flow and action TW30	To report to Emergency Pathway Crisis Intervention Working Group		30/5/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
Compliance action 10 to ensure dignity and privacy of patients being met in Clinical Decisions Unit is progressing in line with agreed timeframes				
Areas of concern for escalation:				
Review of DSSA guidelines affecting options appraisal, financial and PFI constraints on estates work				

Compliance action 11				CA11
Issue: *The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.*				
Lead: *Paul Sigston, Medical Director*		**Operational Lead:** *Wilson Bolsover, Deputy Medical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Reinforce requirements of Health Care Record keeping amongst multidisciplinary staff, including timely recording of actions undertaken by: 1a. Record Keeping champion for department who will be a source of information and support for record keeping standards 1b. Investigate the possibility of providing a name stamp for staff 1c. Staff involvement in record keeping audit	Scoping the problem: Wilson Bolsover will meet with medical records manager and clarify about process around medical records management and where responsibilities lie.	1. Minutes of Directorate Clinical Governance meetings 2. Staff audit pilot 3. Record keeping champion program and list 4. Report on name stamps for staff and recommendations 5. Induction programme for new doctors 6. Report from task and finish group on records	1a. 1/6/15 1b. 1/6/15 1c. 1/6/15	
2. Review induction programme for new Doctors to ensure adequate training provided.	Wilson Bolsover will be reviewing the current induction programme and content and advise on changes		1/5/15	
3. Multidisciplinary Task and Finish group (sub-group of health records committee) to review current notes with fresh eyes and consider where improvements can be made	Meeting will be sent up shortly, identifying appropriate attendees and suitable dates		1/6/15	
4. Record keeping audit to be included in case reviews at Directorate Clinical Governance Meetings	Audit department to update on the current record keeping audit		1/9/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): N/A				
Assurance statement :				
Actions running to time				
Areas of concern for escalation:				
None identified at present				

Compliance action 12				CA12
Issue: *Contracted security staff did not have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.*				
Lead: *Jeanette Rooke, Director of Estates and Facilities*		**Operational Lead:** *John Sinclair, Head of Quality, Safety, Fire and Security*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Provide documentation outlining the joint partnership with our contractor in regards to the provision of training.	Draft proposal sent to Interserve, awaiting confirmation	1. Agreed documentation on joint partnership arrangements 2. Induction Attendance / compliance report on all existing security staff to Security Group 3. TNA document 4. Report on training compliance to Security Group 5. Certificates of training 6. Certificates of training	1/4/15	
2. All contractors to attend the Trust approved and agreed Induction Training and attend the Trust mandatory training	All Security Staff have completed the mandatory Trust training courses apart from two new starters who are currently going through registration processes.		1/4/15	
3. Contractors to be included on the Training Needs Analysis document outlining all requirements, frequency and levels	This can be evidenced by the attached email evidencing our L&D confirming a place on a requested course.		1/5/15	
4. Review compliance with all training requirements against existing security team	Security Contractor have 100% compliance rate in accordance with BSIA and ACS		1/5/15	
5. The Security Manager to provide training logs for the SMART Risk Assessment Training undertaken through one to one sessions with all security officers.	Security Manager has completed SMART Risk Assessment Training with 95% of the personnel deployed to both sites. The remaining employees will receive said training by the scheduled action completion date. SMART- Safeguarding Managing Risk Tool. Used to assess high risk patients.		1/5/15	
6. All current security staff to be booked onto and attend Mental Health Awareness Training and dementia awareness training	All contracted Security Staff have been booked on Mental Health Awareness Training and Dementia Awareness Training courses provided by the Trust. All staff will have completed all above training by August 2015. Course feedback reviews will be undertaken to ascertain whether further higher level of training is required to provide the necessary support to meet the appropriate needs.		1/8/15	
Action Plan running to time: **Yes except action 1**				
Evidence submitted to support update (list): none submitted				
Assurance statement :				
Actions running to time				
Areas of concern for escalation:				
None reported				

Compliance action 13				*CA13*
Issue: *The process for incident reporting did not ensure that staff were aware of and acted in accordance with the trust quality and risk policy.*				
Lead: *Avey Bhatia, Chief Nurse*		***Operational Lead:*** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	***Monthly summary update on progress***	***Evidence required***	***Action completion date***	***Rating***
1. Staff leaflet on Trust Quality and Risk Policy, including incident reporting process to be produced in collaboration with staff and distributed to existing staff and new starters at induction	Leaflet draft commenced, work will continue in April	1. Leaflet + audit of distribution and staff engagement through survey 2. fully implemented intranet and web page 3. Datix Staff survey + reporting figures / by profession 4. Education presentation + staff survey 5. Newsletter every month	1/5/15	
2. Governance page to be developed on the intranet and MTW website with clear signposting to Incident Reporting section	Allocated lead for this work. Will be arranging a task finish group starting April to achieve this task. Bolder reporting incident button already changed on intranet front page		Intranet 1/6/15 Website 1/10/15	
3. Incident reporting process currently under review, with full collaboration with clinical staff, to improve reporting process and investigate possibility of hosting reporting portal on mobile media	Draft proposal written and plan is to undertake some collaborative work with staff over next month		1/6/15	
4. Education / update program on Governance, Quality and Patient Safety including incident reporting and learning lessons from incidents to be rolled out to all medical and nursing staff over next year	Identified within team and included in Governance team strategy, this work will only be implemented once resourcing allows. This is expected within next 2 months		1/9/15	
5. Continue to publish articles on Governance Gazette Newsletter relating to incident reporting and learning lessons. Encourage staff to write their own articles for publication.	Aprils Governance Gazette is a focus on leaning from incidents relating to sharps		monthly	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): draft proposal + Governance Gazette				
Assurance statement :				
This action plan has been commenced and leads identified.				
Areas of concern for escalation:				
Patient safety team is awaiting recruitment of a 6month secondment Patient Safety Manager who will help implement some of these required changes. Recruitment expected May / June 2015				

Compliance action 14				CA14
Issue: *The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate*				
Lead: *Hamudi Kisat, Clinical Director & Johnathan Appleby, Clinical Director*		**Operational Lead:** *Hamudi Kisat, Clinical Director & Johnathan Appleby, Clinical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Meeting between senior clinicians and managers Children's services directorate and Surgical directorates to establish clear roles and responsibilities of the care of children on the paediatric ward	Meeting held on 9th April 2015	1. Minutes of joint meeting 2. Standard Operating Procedure 3. Audit of practice 4. MTW Clinical Governance Strategy 5. Agenda, Minutes and attendance records from CG meetings	1/5/15	
2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards	SOP drafted for circulation and discussion		1/6/15	
3. Implementation of the SOP into routine daily practice	Awaiting for above actions to conclude		1/8/15	
4. Trust to develop a consistent approach to Clinical Governance through MTW Clinical Governance Strategy developed in collaboration with internal and external stakeholders	Drafted outline of clinical governance approach in SOP out for circulation and discussion		1/9/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): draft SOP				
Assurance statement :				
This action plan is running to time currently				
Areas of concern for escalation:				
None reported				

Compliance action 15				CA15
Issue: *The children's directorate risk register did not ensure that risks are recorded and resolved in a timely manner.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Karen Carter-Woods, Risk and Governance Manager*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. A full review of the directorate risks	Completed: discussed at Directorate meeting 27th March and further risks identified to go on register agreed	1. Risk register shows children's section managed in a timely manner 2. Minutes of Directorate meeting / Clinical Governance meeting	1/5/15	
2. An update session for all senior nursing and medical staff on the purpose and process of the risk register	To be included on nurse update day 23rd April & Clinical Governance session May 14th		16/6/15	
3. Ensure review of risk register is standing agenda item at Directorate meetings / Clinical Governance meetings	Already standing agenda item at Directorate meetings To be included in CG meetings		16/6/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Directorate R&G report **(**March)				
Assurance statement :				
Heightened awareness of staff involvement in paediatric risks ongoing within the directorate				
Areas of concern for escalation:				
Nil				

Compliance action 16				CA16
Issue: *There were two incident reporting systems, the trust electronic recording system and another developed by consultant anaesthetists and intensivists one for their own use. The trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons.*				
Lead: *Avey Bhatia, Chief Nurse*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Anaesthetic incident reporting pilot discontinued. Those involved in running this system, and other clinical staff fully engaged with the review on the DATIX system to improve reporting process	Confirmation e-mail from the lead for the anaesthetic pilot that this is discontinued. Meeting regarding Datix improvements held in March, further meeting planned for April – multidisciplinary attendance	1. Written Confirmation from coordinator of system 2. Leaflet audit of distribution and staff survey 3. Newsletter article 4. Increased incident reporting through single reporting system from anaesthetist and intensivists	1/2/15	
2. Staff leaflet to include reminder about rationale for single reporting system	In draft at present		1/5/15	
3. Reminders in Governance Gazette and via intranet and website about the SINGLE reporting system in the Trust.	Will be in May Governance Gazette		1/5/15	
4. Assc. Dir. Quality, Governance and Patient Safety to attend Anaesthetic CG meeting for discussion and update on reporting system	Will attend May Clinical Governance		1/5/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): e-mail confirmation				
Assurance statement :				
This action is running to date at present				
Areas of concern for escalation:				
None				

Compliance action 17				CA17
Issue: *There was a lack of engagement and cohesive approach to clinical governance. Mortality and morbidity reviews were not robust, not all deaths were discussed and there was no available documentation to support discussions.*				
Lead: *Paul Sigston, Medical Director*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Full review and collaborative process involving all stakeholders for developing and implementing a cohesive and comprehensive clinical governance system from ward to board	Draft CG strategy commenced. External consultant commenced 13th April to provide expertise and assist in implementing agreed revised governance structure	1. CG strategy including clear CG process from ward to board 2. M&M review documentation of full review process and evidence of clear discussions and shared learning 3. Update outline and attendance	1/9/15	
2. Development of a MTW Clinical Governance Strategy	Will commence alongside review process above		1/7/15	
3. Mortality and morbidity review process to be reviewed in collaboration with stakeholders and developed with exploration of further use of technology and clinical governance processes to improve rigor, transparency and effectiveness	Initial review undertaken and areas identified to improve the process and flow of information. Initial meeting with health informatics to ascertain how IT can assist supporting the process		1/8/15	
4. Update for staff involved at directorate and Trust level on their role in the mortality & morbidity review process	Will commence once review completed and new system in place		1/10/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): none				
Assurance statement :				
This action plan is running to time at present				
Areas of concern for escalation:				
None at present				

Compliance action 18				CA18
Issue: *The arrangement for the management and administration of topical anaesthetics was ineffective.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Jenny Head, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure for the administration of topical anaesthetics for children to be developed and implemented	SOP written and in place within paediatric wards	1. SOP for children's services. 2. Audit of prescription charts. 3. Training records of staff undertaking PGD training	1/5/15	
2. Topical anaesthetics for children prescribed in all areas of the Trust	Local audit undertaken of patients who required topical anaesthetic on ward.		1/6/15	
3. A number of key staff to undertake PGD training to facilitate appropriate timeliness of prescribing.	One nurse has completed PGD training 47 staff are booked onto study days starting 15/4/15. Bands 6's are the first to be trained.		1/7/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): 1. SOP 2. Audit results **3.** Dates for staff undertaking PGD training.				
Assurance statement :				
The actions for the management and administration of topical anaesthetic are nearly complete. The training of the majority of senior staff to use PGD's will take until the end of May. Audit undertaken was 86% compliance. Action from this is to remind all staff including A&E staff about prescribing topical anaesthetics.				
Areas of concern for escalation:				
None				

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - April 2015

4-12 Safeguarding Children Report Covering Period Jan 2014 - March 2015 Chief Nurse

Summary / Key points

The purpose of the enclosed report is to update the Trust Board on the progress made in relation to safeguarding children since the last report in January 2014.

Significant work has been done in the last year in relation to improving services for children and safeguarding arrangements at Maidstone and Tunbridge Wells NHS Trust, and we remain vigilant to ensure we deliver against areas as identified to continue to make improvements.

The enclosed report provides information on:

- Section 11 audit
- Ofsted/CQC inspections
- Coping with crying pilot programme
- Common assessment framework (CAF) /Early Help
- New and revised policies in relation to safeguarding children
- Flagging children with child protection plans
- Female Genital Mutilation
- Multiagency Maternity Hub
- Serious Case Review
- Referrals to social services
- Safeguarding Children Training
- Areas of risk

Which Committees have reviewed the information prior to Board submission?

- Safeguarding Children Committee

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Safeguarding Children Annual Report 2014

1.0 Introduction

1.1 The purpose of the enclosed report is to update the Trust Board on the governance arrangements and progress made in relation to safeguarding children since the last report in 2014. Every Trust Board requires an update at least every year advising of key issues relating to the safeguarding of children. The Board is reminded that children are defined by the Children Act as young people up to but not including their 18th birthday.

1.2 Clearly there are many services that are accessed by children but the main responsibility for the care and safeguarding of children in hospital is with the Children's Directorate.

1.3 This report provides assurance to the Trust Board that the organisation meets the recommendations stated within the review and makes the following declaration as requested by the Department of Health.

- The organisation meets the statutory requirements in relation to the Disclosure and Barring Service (DBS) checks
- Child protection policies are up to date
- Staff have undertaken safeguarding training
- Designated and/or named professionals are clear about their role and have sufficient time and support to undertake it
- There is a Board level Executive Director for safeguarding. The Board reviews safeguarding across the organisation at least once a year to assure it that safeguarding systems and processes are working.

1.4 Safeguarding Children Governance arrangements:

Chief Nurse is responsible for:

- Safeguarding children practice and assumes a strategic lead on all aspects of the Trust's contribution to safeguarding children.
- Representing Maidstone and Tunbridge Wells NHS Trust on the Health Safeguarding Group a subcommittee of the Kent Safeguarding Children Board.
- Ensuring that appropriate safeguarding processes are in place, including compliance with all legal, statutory and good practice requirements

The Safeguarding Children Committee forms an integral part of the governance system and is chaired by the Chief Nurse. Membership of the committee includes the Head of Midwifery, Named Doctor, Named Nurse, Named Midwife, A/E Safeguarding Lead, Matron for Paediatrics, CCG Designated Safeguarding Lead Nurse and Lead for Learning and Development. The Named Doctor for Safeguarding Children is now Dr Niki Pandya. Dr Charles Unter works part time in his role as Designated Doctor for child death. The Named Nurse, Jo Howe, has two part time Safeguarding Children Nurses working with her.

1.5 The Trust supports staff in the identification and management of issues relating to Safeguarding Children.

1.6 The child's welfare is seen as paramount and staff ensure the child's safety is their first consideration.

1.7 Staff are working collaboratively with other agencies involved in safeguarding children.

1.8 Mandatory training updates for Child Protection are attended initially at Trust Induction, then, are required every three years by all staff within the Trust. Levels of training aim to encompass all National and Local guidance pertaining to content and competencies with specific reference to those most relevant to MTW.

Level	Venue	Attendance Criteria
1	Internal	Mandatory for all MTW staff (clinical and non-clinical). This level is part of the mandatory induction programme.
2	Internal	Mandatory for all MTW Clinical staff who have regular contact with children and young people and/or parents/carers.
3	Internal	Recommended for all MTW senior registered clinical staff working with children, young people and /or their parents/carers and in Emergency Services.

In addition the Named Nurses provide bespoke training sessions for clinical staff in midwifery, paediatric, emergency care areas and for the F1/F2 intakes. Level 1 and 2 training is also available through an e-learning package on the internet making it accessible off-site and out of hours and is linked to other resources.

1.9 Safeguarding Children Supervision is available as required for all staff involved in Safeguarding Children; the Trust has accessed such external supervision for its Named Nurse. These individuals equally provide supervision for all staff including Medical and Nursing staff. The Named Nurse has established a formal record for supervision provided internally.

1.10 **Section 11 audit**

It was agreed by the Kent Safeguarding Children Board's Executive group that Section 11 compliance in Kent will be assessed in full on a two yearly basis, with a focussed follow up in the intervening year. MTW undertook their Section 11 audit in January 2015 – March 2015 and are awaiting response from the KSCB.

1.11 **Ofsted Inspections**

There have been no Ofsted inspections in 2014

1.12 **CQC Safeguarding Review for Looked After Children**

In April 2014 a review of safeguarding was carried out in West Kent including MTW NHS Trust. A fully integrated action plan was developed which has been overseen and monitored by West Kent CCG.

2.0 Summary of Achievements

2.1 **Coping with Crying pilot programme**

Non–accidental head injury (NAHI) is the most common cause of infant death or long term disability from maltreatment (Sidebotham and Fleming 2007). NAHI are most common in babies under 6 months with the incidence of NAHI following a similar pattern to the incidence curve of crying starting to peak at about 2 months. The NSPCC have invited MTW to participate in a programme aimed at supporting parents and reducing the risk of them losing their temper and harming their baby. Midwives are introducing a DVD to parents at their first home visit following birth followed up by leaflets with coping strategies for babies crying. This was rolled out in April 2014 for an 18 month period and will then be evaluated.

2.2 **Common Assessment Framework (CAF) / Early Help**

There has been a review of the CAF process in Kent last year and the Kent Family Support Framework is now being piloted. The principle of Early Help is still the priority however the referral process has changed. Early Help is discussed at Induction, and on Level 2 and 3 training to ensure that staff have an understanding of what it means and where it fits in terms of thresholds for intervention.

2.3 **Safeguarding Children Supervision**

Community Midwives/Community Paediatric Nurses who carry caseloads with complex families receive formal supervision either on an individual basis or in groups. This is facilitated by the Named Nurse, Safeguarding Children Nurses and the Named Midwife. Midwifery Team Leaders also facilitate supervision in their teams. Formal supervision has been useful to identify whether children require Early Help or whether they meet the threshold for referral to Social Services. Supervision is also a source of support to staff.

2.4 **Trust Missing Children Policy**

This policy was written in 2014 following the review of safeguarding children by the CQC and is available on Q-Pulse. It sets out clear guidelines for staff should a child go missing from the hospital at any time.

2.5 **Trust Paediatric DNA Policy**

This policy was reviewed following the CQC review of safeguarding children. It now includes specific guidelines for Looked after Children to ensure their GP has been informed and they are offered another appointment.

2.6 **Flagging of children with child protection plans (CPP)**

In 2013 MTW signed up to the Joint Information Sharing Protocol for children and young people subject to a CPP. Kent County Council Children's Social Care share information on a weekly basis to the Named Nurse and a flag is put against the child name both on Symphony and Patient Centre.

MTW have signed up to the national Child Protection Information Sharing Service. This means we will have information about any child with a child protection plan attending the Trust or a Looked after Child who attends no matter where they live. This is due to be rolled out over the next year.

2.7 **Mandatory reporting of Female Genital Mutilation (FGM)**

Mandatory reporting of cases by acute trusts to the DOH commenced in September 2014. To date we have had one new case reported. The Named Nurse has joined a multi-agency steering group for FGM to discuss county wide policy and practice in line with national guidance and the plan is for reports from this meeting to feed into KSCB. Information about FGM has been added to the mandatory clinical training at MTW in order to ensure staff are aware of their responsibility to identify and report cases, support women and safeguard girls from being mutilated.

2.8 **Multi agency Maternity Safeguarding Hub**

Following the CQC review of safeguarding children in April 2014 a multi-agency safeguarding hub has been set up in the Maidstone area, chaired by a member of the safeguarding children team on a bi monthly basis. This is a forum to discuss cases of concern and share information in order to safeguard the unborn baby and support the family. This is proving to be very effective and the safeguarding team will be rolling this out in the Tonbridge/Tunbridge Wells area in the near future.

3.0 Serious Case Reviews (SCRs), Internal Management Reviews (IMRs) and Serious Untoward Incidents (SIRIs).

There have been no SCR or IMR for MTW in the last year.

All child deaths are designated as SIRIs and are reported to the Clinical Commissioning Group (CCG). A process is in place for the multiagency investigation of deaths and reporting into a county-wide overview panel, to which the Trust contributes.

4.0 Referral to social services

Staff are required to send copies of referrals to social services and to the Named Nurse so that data can be recorded.

- Data has been gathered for 1st January 2014- 31st December 2014
- There have been 222 referrals into the Central Referral Unit (CRU) from MTW in total.
- 74 of these were made by A/E staff
- 68 referrals have been made by the Safeguarding Children Team on behalf of A/E
- 30 of these referrals were for adults attending with mental health issues/domestic assaults
- 38 were for children attending A/E
- There is an increase over the last year of A/E staff making direct referrals to social services.

5.0 Training

5.1 The Trust's current compliance with level 1 training is 90% and is above the Trust's minimum compliance target for statutory and mandatory training of 85%. Compliance at level 2 is at 81.0 % and efforts are being made to increase communications with regards to statutory and mandatory training. Non-compliance lists for training are being distributed by the HR Business Partners and the Learning & Development team. Reminder emails are being sent out on a regular basis. Compliance is a standing item on the sub-group agenda

Level 3 training was introduced in September 2012 aimed at all clinical staff working with children who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns. The main focus of the training is the assessment of risk, early identification/help and multi-agency working. Compliance is currently at 67.0 % - extra sessions are being put together for A/E staff to improve compliance and ensure practitioners are trained to the required level for safeguarding children.

Every month as part of Trust Induction training pocket cards detailing key information and contacts for Safeguarding Children are distributed enabling staff to keep these important details close to hand at all times.

6.0 Areas of risk for on-going monitoring and review

6.1 The Safeguarding Children Committee continue to monitor compliance with training with a particular focus on improving the compliance at level 2 and level 3.

6.2 A focus on Multi-Agency working particularly with reference to the completion of referrals to social services by A/E staff.

6.3 Protected named midwife hours for safeguarding children are currently being reviewed from within the Women's and Children's directorate to support the safeguarding team.

7.0 Conclusion

7.1 Significant work has been done in the last year in relation to improving services for children and safeguarding arrangements at Maidstone and Tunbridge Wells NHS Trust, with our commissioners and KSCB. There is still work to do to further improve the standards but we are assured that we have the right people and systems in place.

7.2 In the meantime the Safeguarding Children's Committee will continue to report regularly to the Quality and Safety Committee.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – April 2015

4-13	Safeguarding Adults Annual Report	Chief Nurse

Summary / Key points

This report has been prepared to cover the Financial Year April 2014 – end March 2015. Previous reports have been written covering January – December each year and so data has also been included in separate tables for January 2014 –end of March 2014 to ensure that the Trust Board are aware of all available data in relation to Safeguarding Adults.

Key messages are that the Trusts policies and procedures in relation to Mental Capacity Act and Deprivation of Liberty Safeguards have been reviewed this year. The Safeguarding Adults Policy and procedure is currently under review to ensure that it fits with the Care Act 2014 and the newly published Kent and Medway updated Multi-agency policy, procedure and guidance.

A Domestic Abuse Policy was published for use in 2014 and this covers both patients and staff. The Missing Adult Patient policy and procedure was published in March 2015. Staff in the Trust continue to raise Safeguarding Alerts appropriately and this is an indicator that the current training provided is enabling staff to feel confident to raise these alerts to our multi-agency partners.

Level 2 Safeguarding Adults Training has been available since January 2015.

Level 2 Safeguarding Adults E-Learning was developed and now needs updating as a result of the Care Act 2014.

Trust staff are keen to learn from allegations of abuse and put in place remedial actions when investigations highlight any shortcomings in practice.

Which Committees have reviewed the information prior to Board submission?

- Safeguarding Adults Committee

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Information and Assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Safeguarding Adult Annual Report

January 2014 – March 2015

1.0 Introduction

The purpose of this report is to inform the Trust Board about the work undertaken by the Safeguarding Adults Committee during the year January 2014 – March 2015. It is also to give the Trust Board assurance that there are effective mechanisms in place to ensure that our patients are safe from abuse and are safeguarded appropriately whilst they are in our care.

2.0 CQC and Compliance

The Trust continues to declare compliance with the Care Quality Commission (CQC) Regulation 13 Safeguarding service users from abuse and improper treatment.

The outcome of the CQC report published in February 2015 in relation to Adult Safeguarding was on the whole positive in that it was noted that the Trust staff were able to describe how they would get support and advice, who from, and they were able to demonstrate how they would raise their concerns and make referrals. The following are just a few excerpts from the published reports:-

- *Staff we spoke with were all aware of their responsibility to report potential abuse and knew how to do this. Staff knew the name of the trust's safeguarding matron and said they would not hesitate to contact the matron for advice and guidance. Clinical staff valued the support provided by the safeguarding matron.*
- *Staff gave us examples of the management of safeguarding concerns that demonstrated that processes were followed and that staff were engaged in the process.*
- *Staff had a good awareness of the Trust's safeguarding policy and were able to give examples of where they had raised concerns. Most staff had completed the mandatory safeguarding training.*
- *We spoke with four staff regarding their role in ensuring patients were safeguarded from abuse; all were clear about their responsibility to report abuse, as well as how to escalate concerns both internally and externally.*
- *Staff we spoke with were able to talk about their responsibilities under the MCA. They could name the safeguarding matron who led on matters relating to the MCA and gave examples of how they use their expertise.*
- *We saw evidence that where required, formal best interests meeting were held to establish capacity and determine best interests in line with the Department of Health Code of Practice for the implementation of the MCA.*
- *Staff understood the concept of deprivation of liberty and could give examples of where the safeguards had been applied or considered.*

The Trust has in place a Safeguarding Adults Committee with both multi-professional and multi-agency representation. The Committee is chaired by the Deputy Chief Nurse.

The Safeguarding Adults Committee continues to report to the Quality and Safety Committee and the Trust Board gain periodic assurance throughout the year via this route.

3.0 Policies and Procedures Drafted, Reviewed and Updated

The Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DoLS) Policy and Procedure has been reviewed, updated and sent out for consultation as a result of the changes in law with regards to the Deprivation of Liberty Safeguards (further Information below). This is expected to be published in May 2015 once it has been ratified by the Policy Ratification Committee.

The Trusts Safeguarding Adults Policy and Procedure is currently under review as the Kent and Medway Multi-agency Safeguarding Policy, Procedure and Guidance has changed in line with the

Care Act 2014 enacted April 2015. Matron for Safeguarding Adults had already included key elements of the Care Act at the last review of this policy and procedure but remains aware that not all elements had been included. The Trust Domestic Abuse Policy and Procedure was published last year and covers Domestic Abuse responses for both patients and staff members. Matron for Safeguarding Adults has assisted with a number of staff related referrals with regards to Domestic Abuse. The Trusts Missing Adult Patient Policy and Procedure was published in March 201.5

We are currently reaping the learning from this incident and there will be information disseminated to appropriate practitioners from this and minor alterations to the policy and procedure as a result. (The patient was found).

4.0 Levels of Safeguarding Referrals and Outcomes of Investigations

Trust staff continue to refer safeguarding alerts directly to the Kent County Council Central Referral Unit. Trust staff raise safeguarding alerts about concerns for patients when they arrive at hospital and these alerts will cause Kent County Council Family and Social Care Departments to arrange an investigation into the concerns raised.

Trust staff also raise safeguarding alerts about practice within the Acute Trust environment about harm that has occurred to vulnerable adults. Practitioners and providers from outside of the Trust have also made referrals about harm that is suspected to have been caused when patients have been in-patients in the Trust. For these alerts the Trust co-ordinates the investigations and provides feedback to Kent County Council as the lead agency for Safeguarding Adults.

Staff are reminded to copy Matron for Safeguarding Adults into all Safeguarding Alerts made. Safeguarding alerts raised are usually appropriate and where inappropriate referrals have been made e.g. Self Neglect referrals, remedial action and educational opportunities have been taken directly with those practitioners.

From January 1st 2014 – March 31st 2014 the total number of Safeguarding Alerts raised was twenty-nine, of which twenty were for community investigations and nine were for hospital investigations. Of these 9 hospital investigations, 8 were allegations in relation to staff members or failures in care systems and 1 was in relation to a relative. Six of these allegations were not upheld and three were inconclusive (see table 1)

The Trust does not always receive feedback with regards to community Investigation outcomes however, as we co-ordinate the hospital investigations the following are the outcomes for the allegations of abuse made against, or from within the hospital.

Table 1: Safeguarding Alerts for Hospital Investigations and Outcomes, January 2014 – end of March 2014

January 2014 – March 2015	OUTCOMES						Total Numbers
	TWH			MAIDSTONE			
	Upheld	Not Upheld	Inconclusive	Upheld	Not Upheld	Inconclusive	
JAN	0	0	0	0	2	1	3
FEB	0	2	0	0	0	1	3
MAR	0	1	0	0	1	1*	3
TOTAL							9

*This occurred in the hospital but it was the family member who was accused of harming the patient.

5 cases were alleged neglect; 3 cases were alleged physical abuse – rough handling and 1 of sexual abuse.

Table 2: Safeguarding Alerts for Hospital Investigations and Outcomes, April 2014 – end of March 2015 (Inc = inconclusive)

April 2014 – March 2015	OUTCOMES								Total Numbers
	TWH				MAIDSTONE				
	Upheld	Not Upheld	Inc	Await Report	Upheld	Not Upheld	Inc	Await Report	
April	0	0	0	0	0	0	0	0	**0**
May	0	2	0	0	0	1	0	0	**3**
June	0	1	0	0	0	0	0	0	**1**
July	0	4	0	0	0	2*	0	0	**6**
Aug	0	0	0	0	0	4	0	0	**4**
Sept	1	3	2	0	1	0	0	0	**7**
Oct	2**	1	0	0	0	1	0	0	**4**
Nov	1	3	0	0	0	1	0	3	**8**
Dec	0	1	0	1	0	0	0	0	**2**
Jan	0	1	0	0	0	0	0	0	**1**
Feb	0	0	0	1	0	0	0	0	**1**
March	0	0	0	1	0	0	0	0	**1**

* one of these alerts was a staff member to staff member incident occurring on hospital premises.

** one of these alerts was raised as a husband was witnessed to have abused his wife, but it occurred in the hospital setting.

From April 2014 – end of March 2015 the total number of safeguarding alerts raised was 124 of which 38 incidents were alleged to have occurred in the hospital settings – 25 at TWH and 13 at Maidstone. 36 alleged incidents were in relation to staff or failure in care systems, 1 was a staff to staff incident and 1 was in relation to a relative.

Of the 36 alleged cases of abuse involving staff or systems failures 22 were with regards to neglect 11 of which are in relation to Pressure Ulcers. Four reports remain outstanding and seven have proven to be not upheld.

Of the 36 alleged cases of abuse 6 were allegations of physical abuse, amounting to 'rough handling or common assault'. Five of these were not upheld and 1 was upheld with remedial action having been taken.

Of the 36 alleged cases of abuse 8 were allegations of emotional abuse, none of which were upheld.

The Safeguarding terminology with regards to outcomes of cases used in the Table 1 has been simplified for ease of the table requirements to **upheld or not upheld**. In Safeguarding Adults the following terminology is used:

a. Unsubstantiated - Discounted
b. Substantiated - Confirmed
c. Partially Substantiated - Some aspects of abuse confirmed
d. Not determined/inconclusive or evaluated as not being abuse

Therefore in cases above where the allegation was partially substantiated these have been counted as upheld.

Most allegations of abuse alleged to have occurred in the Hospital setting are managed through the Serious Incident Reporting mechanism. However, the Trust also adheres to the Kent &

Medway Multi-agency Safeguarding Adults Policy, Procedure and Guidance and raises these as Safeguarding Alerts with the Local Authority.

5.0 Multi-agency Partnership Working

The Trust has strong representation within the Multi-agency both strategically and operationally. Providers of statutory services are now effective participants on the Kent & Medway Safeguarding Adults Executive Board with the Deputy Chief Nurse representing the Trust on the Board and Matron Safeguarding Adults as delegate. This provides the Trust with the opportunity to contribute to the strategic development of safeguarding adults activity within the County ensuring that the interests of acute care providers is represented at a senior level.

The Executive Board has health representatives from the Clinical Commissioning Groups (CCGs) across Kent and East Sussex, NHS England Local Area Team, and Mental Health & Community Partnership Trusts. This Executive Board communicates strategic intention and operational requirements via a sub-committee/group structure.

There are four sub-groups to the Executive Board:-

- Quality Assurance Working Group – (QWAG)
- Learning and Development Group – (L&D)
- Policies, Procedures Group, - (PPG)
- Serious Case Review Panel – when SCR referrals are made

Although it was agreed at Executive Board level that the Acute Trusts would have one nominated Safeguarding Adults' representative and a deputy for the first two meetings listed above, this has not been effective over the last year and so Matron for Safeguarding Adults will be attending the first 3 meetings listed on a regular basis. This so that our Trust can participate effectively in shaping the Safeguarding Adults work plan in the forthcoming year and give effective feedback to our Trust with regards to the direction of travel over the next year.

Of note the Executive Board have updated their Safeguarding Adults Multi-agency Policy, Procedure and Guidance as a result of the enactment of the Care Act 2014 and so this means that the Trusts Safeguarding Adults Policy and Procedure is currently under review.

Matron for Safeguarding Adults also attends the Mental Capacity Act (MCA) Local Implementation Network Meeting and its subgroups assisting with the application of the MCA/DOLS in practice and training delivery.

Attendance at the two local Multi-Agency Risk Assessment Conferences (MARAC) is shared equally between the Children's Safeguarding Lead Nurse and Matron for Safeguarding Adults. The Trust maintains high visibility with regards to partnership working in the Safeguarding Multi-agency arena.

The Trust continues to work closely with the Community Learning Disability Link Nurses and they have an agreed work plan for this year to ensure that their liaison role is understood by trust practitioners and that their expertise and skill is used effectively to ensure that patients with a Learning Disability have a positive patient experience. Matron for Safeguarding Adults, or delegated representative, represents the Trust on the Learning Disability Commissioning Meeting the Good Health Group to ensure that the Trusts work streams in relation to meeting the needs of people with Learning Disability remain current and on track.

It is acknowledged that most Trusts have a dedicated Learning Disability nurse in post to support with emerging themes and complex cases in relation to Learning Disability and the Trust is considering their position in relation to this.

6.0 Education and Training in Safeguarding Adults

There is a suite of training programmes coordinated by the Learning & Development team that has been reviewed and updated in line with the Care Act Guidance 2014.

We now offer Basic Awareness (Level 1) in Adult and Children's Safeguarding via e-learning for all new starters prior to their start date at the Trust. Level 2 Safeguarding Adults is delivered to Clinical Staff on the first day of their employment in the Trust within Clinical Trust Induction. This means that clinical staff are able to start with an appropriate level of training when dealing with issues for adults who may be at risk of harm.

Level 2 Safeguarding Adults Clinical Update is delivered on a regular basis and includes:-

- The Care Act – Six Principles, Types of Abuse, Lead Agency, Safeguarding Adults Boards, Safeguarding Adult's Reviews, Domestic Homicide Reviews
- Safeguarding Adults Processes – Definitions, Referrals, Investigations, Making Safeguarding Personal, Police Investigation
- Applying the Mental Capacity Act and Deprivation of Liberty Safeguards
- Making Reasonable Adjustments
- Domestic Abuse
- PREVENT
- Learning from Investigations

The Training packages have been developed in collaboration with the wider Safeguarding Adults team and training beyond initial awareness is available from our Multi-agency training delivered by the Kent Medway Safeguarding Adults Board.E-learning packages are available via the Trust intranet for all staff groups. The basic awareness e-learning package has been reviewed and updated. Last year the Trust developed a Safeguarding Adults Level 2 training programme. This now needs to be reviewed and updated as a result of the Care Act 2014.

Level 2 (e-learning and face to face training) is aimed at all clinical staff who have some degree of contact with adults, carers and their families.

The Trust has been required to deliver PREVENT training to practitioners within the Trust. PREVENT is part of the Government's counter-terrorism strategy CONTEST and so raising awareness of what staff can do if they are concerned that either a patient or colleague is becoming radicalised is advocated by the DoH and Home Office. Matron for safeguarding is the trusts trained, trainer and the PREVENT Lead. To date 62 Clinicians have received this training. A slide about the PREVENT strategy is included in the Trust Clinical Induction and the Clinical Update to inform staff about who to refer to if they have any concerns about a colleague or a staff member. PREVENT training is included in the newly developed Level 3 Safeguarding Adults training. Matron for Safeguarding has agreement from colleagues within the Multi-agency to assist with delivery of this training.

The first Level 3 training is due to be offered in May 2015 and will include:-

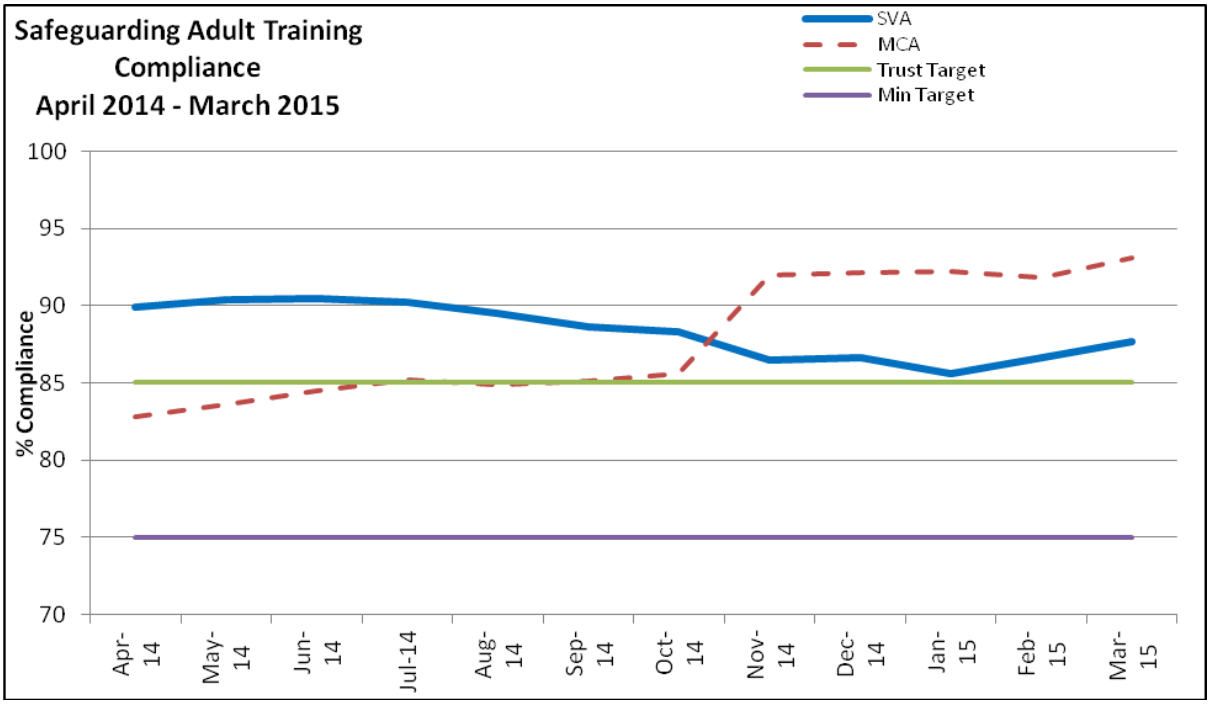
- Safeguarding Adults at Risk of Harm – Social Care Practitioners
- Criminal Investigations – Detective Inspector
- Domestic Abuse – Detective Inspector
- Learning Disability – Matron SA and Community Learning Disability Link Nurses
- MCA and DOLS - Matron SA
- PREVENT – Matron SA

This training will initially be aimed at Matrons and Clinical Band 7's.

Given below is the up to date graph with regards to training compliance within the Trust. Overall compliance with regards to Safeguarding Adults remains above the Trust minimum standard. Those areas that are below 80% compliant are routinely targeted by the Learning and Development Department to encourage improvement in these areas. The Safeguarding Adults Committee continues to monitor this compliance.

Mental Capacity Act compliance continues on an upward trend and the Safeguarding Adults Matron continues to focus on MCA and Deprivation of Liberty Safeguards within the Clinical Trust Induction and Clinical Update with this learning being more detailed at Level 3.

Table 3: Safeguarding Adults Training Compliance April 2014 – March 2015



7.0 Audit and Monitoring

The Trust Safeguarding Adults Committee reviews all Safeguarding Cases that have been raised by Trust staff and ensures that when these are Hospital investigations that the investigation progresses in a timely manner.

External scrutiny is given to these cases and investigations from the Local Authority and CCG Safeguarding Designated Nurse as Matron for SA meets monthly with the Safeguarding Adults Co-ordinators and the CCG Safeguarding Adults' Designated Nurse to review the alerts raised and the investigations undertaken. It is at this stage that the decision is made as to whether or not abuse is upheld. This model of practice between Acute Trusts and the Local Authority has been adopted now throughout Kent.

Matron SA monitors all Adult Protection 1 (AP1) referrals completed by Trust staff and is able to respond promptly to ensure that appropriate and accurate information is recorded to ensure that appropriate levels of investigations can be initiated.

The information that staff are recording to raise alerts is informative and shows that Trust staff understand the Multi-agency processes and continue to take Safeguarding Adults Seriously.

It remains a challenge implementing the Mental Capacity Act into everyday practice. However, it is of note that staff are gaining in confidence to run their own Best Interest Meetings and do not always feel that they require the support of the Matron for Safeguarding Adults.

8.0 Serious Case Reviews, Domestic Homicide Reviews, Independent Management Reviews

There have been no serious case reviews published in 2014 that involved Maidstone & Tunbridge Wells NHS Trust. The Trust has participated in one Domestic Homicide Review and we await the outcome of DHR12.

9.0 Learning and Action Plans

At a local level learning from alerts is distilled at the Safeguarding Adults Committee and disseminated to relevant groups. Learning is incorporated into future training and raised at key departmental meetings.

The Trust has in place a core action plan to address the issues resulting from audit, and outcomes from safeguarding investigations. This action plan informs local departmental improvement plans. It also informs work that is required within the Multi-agency across Kent to improve responses and systems, policies and procedures, in place, to address safeguarding concerns. Improvement plans are in place to specifically address learning disability, mental capacity assessments, and PREVENT training. Action plans are monitored by the Safeguarding Adults Committee. A quarterly report is submitted to the Quality and Safety Committee by the Deputy Chief Nurse highlighting issues of both concern and good practice. The Safeguarding Adults Committee has the operational responsibility for the development and implementation of the action of the plans.

10.0 Deprivation of Liberty Safeguards – DOLS

The application of DOL Safeguards has been widened following a Supreme Court ruling. This ruling (P v Cheshire West and P&Q v Surrey County Council) was issued March 19th 2014, and resulted in the formulation of the 'acid test' to enable practitioners to establish whether or not a person is deprived of their liberty. The board has received regular updates on the Trust's progress with the new requirements for the application of DOLS (March 2015 Quality and Safety report).

11.0 Conclusion

As detailed in the report the majority of allegations against the Trust staff or systems have not been upheld.

Staff are confident to raise adult protection alerts as the number of alerts increased from **113** Safeguarding Alerts Jan 2013 – Dec 2013 to **124** April 2014 – March 2015, **29** were also raised from Jan 2014 – March 2014.

Training with regards to Safeguarding Adults is enabling staff to feel confident about the Multi-agency processes and the importance of raising their concerns appropriately and in a timely fashion.

There is a plan to continue focussing on Mental Capacity Act and Deprivation of Liberty Safeguards training in 2015.

Safeguarding adults continues to have a high profile with continuing significant improvements seen overall. The Trust has a good reputation within the Multi-agency setting in relation to its responses to safeguarding adult concerns, raising appropriate referrals and safeguarding people appropriately.

All key elements are in place to ensure patients are kept safe and that hospital investigations are managed in a robust manner

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board – April 2015

4-14 Safe Staffing: Planned V Actual – March' 15 Chief Nurse

Summary / Key points

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the month of March 2015. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

The report also includes some nurse sensitive indicators to support the professional judgement of safe delivery of care. Nurse sensitive indicators are those indicators that may be adversely impacted on if staffing levels are insufficient for the acuity and dependency of the ward. These indicators are supported by the Department of Health and latterly by the NICE review of ward staffing published in July 2014.

The RAG rating for the fill rate is rated as:

Green: 100%
Amber <90%
Red <80%

The principle being that any shortfall below 90% may have some level of impact on the delivery of care. However this is dependent on both acuity and dependency. Acuity is the term used to describe the clinical needs of a patient or group of patients, whilst dependency refers to the support a patient or group of patients may need with activities such as eating, drinking, or washing.

The exception reporting rationale is RAG rated according to professional judgement against the following expectations:

- The ward maintained a nurse to patient ratio of 1:5 – 1:7
- Acuity and dependency within expected tolerances
- Workforce issues such as significant vacancy
- Quality & safety data
- Overall staffing levels
- Risks posed to patients as a result of the above

The **overall** RAG status gives an indication of the safety levels of the ward, compared to professional judgement as set out in the Staffing Escalation Policy. The arrow indicates improvement or deterioration when compared to the previous month. The thresholds for the overall rating are set bout below:

RAG	Details
	Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix. RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time.

	OR Staffing numbers not as expected but reasonable given current workload and patient acuity.
	Moderate Impact: Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level. OR Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required. Requires redeployment of staff from other wards RN to Patient ratio >1:8 Elements of clinical care not being delivered as planned
	Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix. Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

Which Committees have reviewed the information prior to Board submission?
- Safeguarding Children Committee

Reason for receipt at the Board. (decision, discussion, information, assurance etc.) [1]
Assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Planned versus actual March 2015

Hospital Site name	Ward name	Specialty	Day		Night		Nurse Sensitive Indicators					
			Average fill rate - registered nurses/midw	Average fill rate - care staff (%)	Average fill rate - registered	Average fill rate - care staff (%)	FFT Response	FFT Score	Falls	PU - ward acquired	Overall RAG	Comments
Maidstone District General Hospital	Acute Stroke	300 - GENERAL MEDICINE	95.2%	112.1%	100.0%	187.1%	38%	75	3	0	↑	
Maidstone District General Hospital	Romney	314 - REHABILITATION	94.6%	101.1%	100.0%	98.4%			3	0		
Maidstone District General Hospital	Cornwallis	100 - GENERAL SURGERY	96.4%	109.7%	100.0%		43%	82	1	0		
Maidstone District General Hospital	Coronary Care Unit (CCU)	320 - CARDIOLOGY	77.4%	N/A	98.4%	N/A	47%	89	0	0		Ccu co-located on Culpeppeer Ward. Staff moved according to overal acutity & dependency. Cover for breaks, complex interventions provided by Culpepper
Maidstone District General Hospital	Culpepper	320 - CARDIOLOGY	98.4%	100.0%	96.8%	100.0%	55%	94	1	0		
Maidstone District General Hospital	Foster Clark	340 - RESPIRATORY MEDICINE	95.5%	114.0%	103.2%	114.5%	53%	83	4	1		
Maidstone District General Hospital	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE	94.2%	42.6%	96.4%	N/A	33%	100	0	0		Planned fill rate reduced 'on the day' due to low acutity. CSW fill rate minimal impact due to low acuity.
Maidstone District General Hospital	John Day	301 - GASTROENTEROLOGY	80.0%	109.7%	97.8%	122.6%	20%	27	7	1	↓	96 hrs unfilled plus, escort to Medway on 2 occaisioins. 6 pts required 1:1 nursing care
Maidstone District General Hospital	Jonathan Saunders	430 - GERIATRIC MEDICINE	104.0%	100.0%	109.7%	100.0%	No responses		7	2		
Maidstone District General Hospital	Lord North	370 - MEDICAL ONCOLOGY	92.4%	93.5%	97.8%	93.5%	39%	80	1	1		
Maidstone District General Hospital	Mercer	430 - GERIATRIC MEDICINE	96.0%	95.7%	97.8%	209.7%	24%	79	5	1	↑	
Maidstone District General Hospital	Pye Oliver	100 - GENERAL SURGERY	94.9%	177.4%	96.8%	167.7%	39%	65	6	0	↑	Escalted beds + vacancy. Increased CSW numbers to meet dependency needs
Maidstone District General Hospital	Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	96.5%	87.8%	129.0%	193.5%	33%	84	1	1		Reduced CSW during the day, minial impact on care delivery. Escalated at night; focus giving to filling night shifts
The Tunbridge Wells Hospital	Acute Stroke	430 - GERIATRIC MEDICINE	91.4%	104.8%	101.1%	106.5%	29%	100	2	0	↓	Personnel issues impacting on fill rates for day shifts. Issue now resolved.
The Tunbridge Wells Hospital	Coronary Care Unit (CCU)	320 - CARDIOLOGY	93.5%	100.0%	100.0%		92%	98	0	0		Minimal impact on patient care. 60 hrs unfilled
The Tunbridge Wells Hospital	Gynaecology	502 - GYNAECOLOGY	89.6%	91.8%	100.0%	100.0%	27%	87	2	0	↓	Support from Gyae Triage according to acuity & dependency
The Tunbridge Wells Hospital	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE	100.4%	96.8%	100.0%	54.8%	No responses		0	1		
The Tunbridge Wells Hospital	Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	96.3%	116.1%	102.7%	114.5%	8%	88	9	0		
The Tunbridge Wells Hospital	SSSU	100 - GENERAL SURGERY	93.9%	N/A	95.5%	N/A	1%	100	0	0		48hrs unfilled. Minimal impact on patient care
The Tunbridge Wells Hospital	Ward 32	110 - TRAUMA & ORTHOPAEDICS	100.0%	100.0%	100.0%	100.0%	27%	77	2	0		
The Tunbridge Wells Hospital	Ward 10	100 - GENERAL SURGERY	94.4%	106.5%	91.9%	137.1%	43%	92	1	0		264 hrs unfilled. 19 shifts had patients requiring 1:1 care.
The Tunbridge Wells Hospital	Ward 11	100 - GENERAL SURGERY	91.2%	109.7%	91.1%	119.4%	41%	88	2	0	↓	300 hrs short. 1 patient required 1:1 care for 24 nights, plus an additional specialing/nursing presence required for 9 nights.
The Tunbridge Wells Hospital	Ward 12	320 - CARDIOLOGY	80.7%	120.4%	79.7%	108.1%	19%	82	4	1		Some impact on patient care. RN:CSW ratio altered to meet dependency needs
The Tunbridge Wells Hospital	Ward 20	430 - GERIATRIC MEDICINE	95.5%	101.6%	99.2%	146.8%	33%	89	7	2		
The Tunbridge Wells Hospital	Ward 21	340 - RESPIRATORY MEDICINE	90.4%	112.9%	92.3%	93.5%	23%	87	4	2		175 hrs unfilled over the month. Some impact on patient care
The Tunbridge Wells Hospital	Ward 22	430 - GERIATRIC MEDICINE	91.1%	100.0%	97.8%	100.0%	84%	81	4	0		
The Tunbridge Wells Hospital	Ward 30	110 - TRAUMA & ORTHOPAEDICS	88.0%	123.5%	88.7%	130.6%	No responses		14	0		Ward 30 & 31 cross cover according to acutiy & dependency. Whilst overall numbers & nurse to patient ratios are within acceptable tollerances, there is a heavy reliance on temporary staffing due to high vacancy
The Tunbridge Wells Hospital	Ward 31	110 - TRAUMA & ORTHOPAEDICS	109.7%	86.5%	95.2%	112.9%	No responses		0	0		
Tonbridge Cottage Hospital	Stroke Rehab	430 - GERIATRIC MEDICINE	92.5%	96.8%	100.0%	100.0%	No responses		3	0		Minimal impact as 60 hrs unfilled were covered by Nurse In charge (=8 shifts)
The Tunbridge Wells Hospital	ante-natal	501 - OBSTETRICS	101.6%	74.2%	100.0%	80.6%			0	0		Midwives move with women during the course of the shift to or from delivery suite. FFT is reported by touch point within care pathway, not by location.
The Tunbridge Wells Hospital	delivery suite	501 - OBSTETRICS	95.3%	88.3%	93.5%	93.5%			0	0		
The Tunbridge Wells Hospital	post-natal	501 - OBSTETRICS	100.7%	70.0%	98.4%	89.5%			0	0		
The Tunbridge Wells Hospital	Gynae Triage	502 - GYNAECOLOGY	100.0%	100.0%	96.8%	93.5%			0	0		
The Tunbridge Wells Hospital	Hedgehog	420 - PAEDIATRICS	102.2%	94.3%	117.2%	100.0%			0	0		Minimal impact. Overal significant improvement on fill rates due to new starters
Maidstone District General Hospital - RWF03	Birth Centre	501 - OBSTETRICS	101.6%	100.0%	98.4%	100.0%			0	0		
The Tunbridge Wells Hospital	Neonatal Unit	420 - PAEDIATRICS	110.2%	51.6%	101.1%	93.5%			0	0		
Maidstone District General Hospital	MSSU	100 - GENERAL SURGERY	109.1%	104.5%	88.9%				1	0	↑	
Maidstone District General Hospital	Chaucer	180 - ACCIDENT & EMERGENCY	96.0%	112.9%	98.4%	126.6%	70%	60	6	1	↑	
The Tunbridge Wells Hospital	SAU	180 - ACCIDENT & EMERGENCY	117.2%	93.5%	146.8%	154.8%			0	0		

↑ indicates an postive move compared to previous month

↓ indicates a negative move compared to previous month

no arrow indicates no change compared to previous month

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – April 2015

4-14 Nursing & Midwifery Safe Staffing Review — Chief Nurse

Summary / Key points

The attached paper provides the Board with information on the most recent staffing reviews. The National Quality Board requires that staffing reviews are undertaken 6 monthly and reported to the Board.

This report covers progress against the recommendations following the last staffing review in September 2014. The paper also provides information on the staffing reviews undertaken in March / April 2015 for wards triggering on triangulation of quality issues, increased use of temporary staffing, high number of vacancies or subject to service improvement/reconfiguration. The review also included non-ward areas and maternity services.

In summary the recommendations from the September 2014 review which made the case for change for 6 wards are all included in the current round of business planning.

For the 21 wards and departments reviewed in March and April 2015, the recommendations support the existing or proposed business planning intentions.

The recommendations fall into two main groups, investment in staff (3 areas) or service development/reconfiguration (6 areas)

Areas for whom there is recommendation for service change are:

- Pye Oliver – move to Cornwallis (smaller bed base) to mitigate both quality issues for surgical patients and staffing challenges.
- Ward 21, support the Directorate in pursuing the potential to establish a respiratory HDU
- Short Stay Surgery (TWH) support the proposal to explore alignment with the Critical Care Directorate to gain leadership support from Theatres and more effective patient pathways.
- Ward 10 to review models of care delivery that may enable an increase in staff at night within existing establishment.
- Paediatrics; support the directorate plans in reviewing wider care pathways and potential for extending opening hours for Woodlands
- A&E support the staffing model for the implementation of rapid access. Need to consider the recommendations within the NICE draft clinical guidelines.

Areas for whom there is recommendation for investment in staffing are:

- Gynae Ward – uplift of 3 wte RNs to ensure safe and consistent cover of ward and EAGU and some management time for Ward Manager.
- SAU – consider an uplift in staffing to address the sustained demands on capacity
- Maternity – support for the directorate in considering medium term investment to meet projected increases in birth rates.

In conclusion the Trust has sufficient staff in the establishment to provide safe and effective care. The challenges are those faced by any organisations which include recruitment and retention, unpredicted changes in acuity, dependency or capacity demand. There are clear processes in place to manage this.

Which Committees have reviewed the information prior to Board submission?
None

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Nursing and Midwifery Safe Staffing Review April 2015

1.0 Introduction:

This paper sets out to inform and update the Board on staffing levels for in-patient wards, and non-ward areas. It also provides an update on the paper presented to board in September 2014. The paper provides detail on the current staffing position against national recommendations, and makes recommendations to support either current course or to build a case for change.

2.0 National Guidance

As part of a wider response to the Francis Report (2013) the National Quality Board (NQB) published a guide to nursing, midwifery and care staff capacity and capability 'How to ensure the right people, with the right skills, are in the right place at the right time' (2013). Expectations from this report are, in part, fulfilled by this review. The guidance for setting safe staffing levels with the NQB report have had subsequent endorsement by the National Institute for Health and Care Excellence in their clinical guideline 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (July 2014).

The principles recommended by the NICE clinical guideline have been used to set the terms of reference for the staffing reviews. A key recommendation from NICE is the use of average nursing hours per patient per day; this is based on acuity (the clinical support a patient needs) and dependency (support required for daily living activities such as personal hygiene, eating, drinking). The process for collecting this data is now well established in in-patient areas. The tool used is the validated Safe Staffing multiplier previously known as the AUKUH acuity and dependency tool. This tool provides an indication of the number staff required expressed as a whole time equivalent (wte).

NICE have also issued draft clinical guidelines for setting staffing levels in Accident & Emergency Departments and Maternity Units. The Trust has contributed to the consultation process for these guidelines, and used the initial draft guidance to support the triangulation as part of the review.

For specialist areas such as Theatres and Critical Care Units (adult and neonatal) guidance from the relevant national bodies and Royal Colleges have been used.

3.0 Ratios:

3.1 Registered to Un-registered ratios

There is a growing body of evidence to support the national bench mark of a ratio of Registered to Un-registered nurses of 60/40.

The Royal College of Nursing has always maintained the ideal ratio should be 65/35. A large scale study led by Dr Linda Aitkin published early in 2014 supported the overall view that a ratio of between 60 – 65% of the direct care should be undertaken by Registered Nurses. The evidence also suggests that if 60% of the registered nursing workforce is educated to degree level this has a direct correlation to patient outcomes including early detection of deterioration and a reduction mortality. The limit to this study is that the sample group relates only to surgical wards.

Maidstone and Tunbridge Wells NHS Trust (MTW) in-patient staffing ratios are set at 60/40 in line with the national benchmark. The exceptions to this are areas where the model of care is more in keeping with community hospital care. For MTW this is Romney ward at Maidstone Hospital.

Ward 22 has a ratio of 50:50. The RN to patient ratio is acceptable, however there is an increase in the number of Clinical Support Workers to support wider environmental safety of patients (falls prevention and absconder prevention).

Other exceptions to the 60/40 ratio are non-ward areas such as theatres, critical care units and neonatal units.

3.2 Nurse to patient ratios

The body of evidence cited previously indicates that optimum care can be delivered with a nurse to patient ratio of between 1:5 and 1:8; the majority of wards within the Trust run at these ratios. Exceptions are changes to acuity or when wards are unable to meet their planned quota of staff in any given shift.

Acuity is a particular concern for the respiratory wards, with the increasing number of patients who have a ‘ceiling of care’ set at non-invasive ventilation (NIV). These patients often do not meet the admission criteria to the main Critical Care Unit or High Dependency Unit. The Respiratory wards have the appropriate skill mix to manage these patients provided the number of patients on NIV does not breach the number for which the establishment was set.

Non-ward areas work to different ratios as agreed by the relevant professional body, as note previously.

4.0 Methodology

The methodology for the staffing reviews has followed the key recommendations from the NQB and NICE. Two methods were utilised as part of the review, the professional judgement tool and the Safe Staffing Tool. Additional intelligence was sourced from data relating to patient experience, including local ward satisfaction surveys, friends and family feedback and complaints relating to nursing care. Patient safety nurse sensitive indicators were also considered. These included the number of facility acquired pressure ulcers, falls and medication errors. There is strong reliability for pressure ulcer and falls incidence, however it is acknowledged that there is under reporting of incidents related to medication errors. This is forming a specific strand of work in collaboration with pharmacy, patient safety and ward teams.

Further sources of intelligence included QuESTT Scores which included a review of factors that altered the score from month to month. The data set was reviewed for the previous Quarter.

5.0 Principles:

A number of key principles for setting staffing levels were already in place. These were reviewed against the recommendations from NQB published last year. Further reviews against recommendations from NICE were also taken into account, as these were circulated widely as part of the NICE review. These were largely unchanged when published in July 2014, and support the findings emanating from the NQB and the Royal College of Nursing.

NICE recommend using a decision support tool (Safe Staffing Tool) and informed professional judgement to make the final assessment of requirements.

The key principles utilised are:

- Supervisory time for ward managers to be built into establishments. The ward manager should be responsible for 'running the ward' Mon-Fri with some weekend shifts (currently being trailed)
- Number of Band 6's per ward (usually 2 per ward)
- RN to patient ratio (between 1:5 and 1:7)
- RN to Clinical Support Worker ratio (aim for 65/35 split)
- Headroom allowance (to cover leave, sickness, study)
- Practice Educator support and supervision

6.0 Review of progress against recommendations from September 2014.

A number of recommendations were made following the last review of ward staffing which was completed in September 2014. The directorates moved forward in implementing most these recommendations and the investment have been incorporated into this year's business planning. However, some wards i.e. respiratory ward 21, although discussed at business planning still require full business case to support and investment.

The previous recommendations and final outcomes which related to 6 wards are noted as:

Foster Clark: *to consider an uplift of 1 RN per dayshift. The evidence for this related to the pattern of patient safety incidents primarily.*

Recommendation accepted by Directorate and is included in the current round of business planning. This ward will be relocating to a new refurbished ward towards the end of 2015. Staffing for the new ward layout has been through several rounds of review.

Ward 21: *to review demand for NIV and tracheostomy care. Safe Staffing acuity scores would suggest an uplift of 4 to 5 wte.*

Recommendation accepted by Directorate; Business Case in development to support the establishment of a respiratory HDU.

John Day Ward: *to consider increasing RN by 1 per night. Explore potential to off-set by decrease in CSW; to consider different roles or use of staff differently to manage and support patients with cognitive impairments.*

Recommendation partially accepted by Directorate: John Day Ward is now relocating as part of a wider service improvement programme. The ward now has a number of dementia buddies to support patients with cognitive impairment (cost neutral as part of the Dementia Buddy volunteer scheme).

The additional RN for nights is being incorporated into the Directorate's business planning and expenditure is already in the baseline.

Mercer Ward: *to consider increasing Clinical Support Worker (CSW) by 1 per night based on dependency scores and pattern of falls and absconders and to consider formalising dementia activities coordinator role within existing CSW budget. Since introduction of role, there has been a*

decrease in the numbers of patients absconding or falling. There has been a decrease in the requirement for 'specials' during the day and an increase in positive family and carer feedback.

Recommendation accepted by Directorate. Additional CSW has been included in the business planning process.

The role of the Dementia Activities Coordinator is in the process of being formalised within the existing budget. Job Description has been finalised and has been for matching and assimilation against Agenda for Change bands.

Ward 20: *to increase the budgeted establishment by 2.53 wte CSW to reflect the cohort nursing approach for patients with dementia/cognitive impairments. This has been in place informally and is reliant on temporary staffing to maintain. Since implementation there has been a decrease in the number of falls and incidence of pressure damage.*

Recommendation accepted by Directorate: additional wte included in business planning. Dementia activities coordinator role has been funded from the Dementia Challenge Fund for 1 year from January 2015.

Stroke Unit – Maidstone**:** to consider increasing CSW establishment by 1 per night to reduce the high reliance on temporary staffing at night to support confused and/or highly dependent patients.

The Directorate was also asked to reconsider the approach to supporting thrombolysis out of hours as this often leaves the ward down an RN for significant periods of time.

Recommendation accepted by Directorate: CSW establishment review is part of the business planning process. Thrombolysis management is part of a wider stroke improvement strategy.

7.0 Current position (wards and non-ward areas reviewed March / April 2015)

The review in March / April 2015 focussed on a number of key areas based on triangulation of data over the preceding 6 months. The reviews followed the methodology described previously. In-patient and short stay wards were reviewed and the detail can be found in appendix 1.

In summary 8 wards were reviewed plus the Short Stay Surgical Unit and Surgical Assessment Unit. The Short Stay Surgical Unit and the Surgical Assessment Unit were reviewed following recent reconfiguration of the nursing teams.

Non-ward areas that were reviewed were maternity services, paediatric services, Accident & Emergency, Critical Care, Theatres and Out-patients.

7.1 Wards

Pye Oliver: currently funded for 28 beds. The ward also cares for a significant number of medical patients which impacts on the overall care that both surgical and medical patients receive. The typical numerical range of medical patients on the ward is between 6 and 18.

The nurse to patient ratio is at the upper limit of acceptable at 1:7 during the day, increasing to 1:9 at night.

The ward has struggled with staff retention over the last year, and as such now has a significant number of newly qualified staff who require significant levels of support to care for complex surgical patients.

The directorate has plans to relocate the ward to Cornwallis. This would result in a reduction in beds, reducing the risk associated with medical patients being placed on a surgical ward. Staffing ratios would be adjusted accordingly.

The Ward Manager has 3 days supervisory/management time.

Recommendation: *support the Directorate plan to relocate the ward to Cornwallis with reduced bed numbers.*

Reinvest an element of associated savings to provide Practice Development Nurse Support for 2 days per week. The PDN should also consider the establishment of a surgical nurse rotation programme to further develop staff and to aid retention.

Gynae Ward: funded for 11 beds plus 5 emergency gynae assessment unit (EGAU) rooms. The EGAU beds are not co-located within the main ward, presenting challenges for cross-cover when staffing shortfalls occur.

The ward, in common with others, has been challenged by having 40% of case-mix being non-gynaecological.

The activity in the EGAU is high for 2 RNs to manage. The unit operates both a bed based case-mix and ward attenders. The EGAU bed base will turn over between 10 and 15 patients per day with an additional ward attender number of 20 per day on average. Ward attender source includes direct GP referral, self-referral, A&E referral and theatre transfers.

The Ward Manager does not have any supervisory/management time,

There have been some team dynamic issues over the last year which has also impacted on sickness/absence, though this is now under control with a clear improvement plan in place. The directorate have undertaken a bottom up review of the service and have identified a need for uplift in staff.

Recommendation: *support the Directorates business planning intentions for 3 wte uplift to ensure sustained consistent cover for both ward and EGAU.*

Ward 21 has had a high number of patients requiring non-invasive ventilation support (NIV). This patient cohort appears to be increasing in size as the approach to care changes. There is clear change in thinking regarding the identification and agreeing ‘a ceiling of care’ whereby patients with long term lung conditions will receive NIV therapy, but are unlikely to fare any better by admission to Intensive Care or High Dependency.

The Safe Staffing figures are broadly in line with the current establishment. However the ward is experiencing a steady turn-over of staff many of whom leave to take up post in critical care units (either at MTW or another Trust).

The ward currently struggles to meet the British Thoracic Society (BTS) recommendations for 1:2 nursing for patients who are receiving oxygen therapy at a 60% concentration plus, or who require 1 -2 hourly suction. The BTS recommendations are also supported by the Intensive Care National Audit and Research Centre (ICNARC).

The Directorate are exploring the option of establishing a respiratory high dependency unit within the ward. Discussions are currently being held with the Critical Care Directorate to establish the

feasibility of Consultant Intensivist cover for the proposed HDU in partnership with the Respiratory Consultants.

Recommendation: *The Directorate to actively pursue their intentions to develop a business case for the establishment of a respiratory HDU. Professional Nursing oversight from the Corporate Team should be sought during the development of the business case to ensure staffing assumptions are appropriate tested and in line with current national practice and guidance.*

Three wards need further monitoring and further discussion before final professional nursing recommendations can be made.

Short Stay Surgery Unit TWH; the SSSU at TWH was split earlier in the year to support the development of the Surgical Assessment Unit. The current set establishments are appropriate for the defined activity of the unit however due to the sustained escalation the staffing requirements change.

Surgical Assessment Unit: operationally the unit works well. However the challenges of patient flow through the hospital has potential to impact on overall care, as frequently the unit has to 'expand' into the Short Stay Unit space.

As escalation challenges are unlikely to ease in the short to medium term the recommendations, which support the Directorate initial intentions, are:

Recommendation: *Short Stay Surgical unit: explore in detail the benefit of brining the unit under the leadership of Theatres (Critical Care Directorate). The combined approach would facilitate a more streamlined approach to theatre list scheduling, facilitate better working between short stay ward and recovery team working (including development of clinical skills) and would allow the Short Stay Surgery Unit to have clear and distinct leadership.*

The SAU should consider an increase in staffing to meet the sustained demands on capacity. This is likely to equate to 2.53 wte uplift. This would meet the NQB recommendation that escalation capacity within established wards or units should be planned for within the establishment thus reducing the risks and costs associated with temporary staffing reliance.

Ward 10: The ward has a heavy reliance on temporary staffing at night. This is not reflected in the demand during the day. This is due in part to the additional CSW on an early shift to enable the ward to manage the C.diff cohort beds. The change in C.diff rates has meant this post can be utilised to support patients with high care needs and enables a cohort approach for patients with cognitive impairment. The ward has recently seen a change in skill mix brought on by a number of senior staff retiring. Similar to Pye, this has meant an increase in the level of support required for junior staff. There may be scope within the establishment to remodel the shifts to allow for an additional CSW at night without significant investment.

Recommendation *review shift patterns to further explore the potential for increasing numbers at night within existing establishment*

Ward 30: elective orthopaedic ward also supporting orthopaedic trauma and medical patients. Key challenges for the ward are managing the elective flow and falls prevention. High dependency levels at night. Trail with a twilight shift was unsuccessful and unable to fill the shift. The directorate business planning intention is to increase the CSWs by 1 per night. This equates to an establishment uplift of approximately 2.53. This would alter the RN to CSW ratio and bring it slightly outside the national recommendation. However the RN to patient ratios would remain

acceptable. A similar approach was taken previously on Ward 31 with very positive results in relation to falls prevention.

Recommendation: *support the directorate's business planning intention to increase the CSW numbers at night by 1 per night.*

7.2 Non-ward areas:

Theatres:

The methodology used for setting safe staffing levels for theatres is as described previously. Evidence base and guidance from the Association of Perioperative Practitioners (AfPP 2008 & 2009) was referred to.

In order to arrive at a safe budgeted establishment a set of key principles need to be agreed and adhered to. These principles have been referred to earlier in this paper. Nurse to patient ratios as described for generic wards are not applicable to operating theatres, and so a different set of criteria needs to be considered. These criterion are supported nationally and from the AfPP.

- The principles for a single operating theatre are:
- Operating Department Practitioner (ODP) x 1
- Scrub Practitioner (either ODP or RN) x 2
- Runner x 1 (may be a CSW)
- Recovery RN x 1

A theatre suite may consist of several theatres, and as such there is a degree of flexibility in requirements for recovery personnel. However these fundamental principles need to be met for each theatre with a theatre suite to ensure safe delivery of care.

Tunbridge Wells Hospital has a theatre suite comprising of 8 theatres (including 8 anaesthetic rooms), 2 dedicated obstetric theatres and 3 recovery areas.

The staffing requirements per day are:

ODP = 8

Scrub = 16

Runner = 8

Recovery = 8

Obstetric Theatres are staffed to the same principles with an additional recovery RN for elective lists. This has been put in place by the team in response to learning from previous incidents and Serious Incidents (SIs). A night service is in place with 1 ODP and 1 CSW on site 21.00 to 08.00 to open and prepare the theatre. The scrub personnel are on-call from home during this time.

For out of hours obstetric theatre cover the minimum staffing set for 1 theatre is on-call on site.

Maidstone Hospital has 8 theatres but not contained in a full suite. The theatre complex comprises of

4 main theatres (1 suite)

2 head & neck theatres

2 day case theatres

2 procedure rooms (chronic pain and brachy therapy)

The theatres are staffed to the same principles as Tunbridge Wells Hospital and have a daily staffing ratio for 8 theatres.

The Maidstone Hospital theatre case mix is predominately elective however the staff also provide cover to a range of satellite services including electrophysiology studies, interventional radiology, line insertion and cover to Priority House for electroconvulsive therapy.

Out of hours cover is provided by a core 'theatre team' with an additional scrub RN due to the isolation from the main surgical team at Tunbridge Wells. The theatre team provide an out of hours service on an 'on call from home' basis.

The ensure the smooth running of the theatre suites the above staffing compliment is supported by a Theatre Coordinator, holding bay coordinator and professional development nurse (1 wte).

The Theatre Coordinator (Band 7) provides a liaison between the site management team, the wards and the individual theatre shift leaders ensuring staff are deployed according to work load demands and skills. Each theatre is led by a Band 6 and is overseen by the Theatre Coordinator. The Theatre Coordinator is supernumerary.

Each Band 7 with budget or management accountabilities is provided with 0.5 days per week for management functions. The Professional Development Nurse oversee the delivery of the Foundations for Theatre Practice and supports the theatre staff gain or maintain competencies in the various sub-specialties.

The team have a number of vacancies with staff in 'pipeline' for recruitment. There are currently no challenges with recruitment and there is the potential to over recruit.

Recommendation: *No recommendations for further staffing investment made.*

Critical Care

The underpinning approach for setting safe staffing levels within Critical Care is based on a concordance of recommendations from the British Association of Critical Care Nursing, the RCN Critical Care Forum and the Critical Care Society published the Core Standards for Intensive Care Units (2013). The recommendations for setting safe staffing levels are based on the acuity and levels of care provided based on national definitions.

The historical definitions have been levels 1, 2 and 3 with level 3 being either full mechanical ventilation plus support for one or more organ/system failure. Level 2 being respiratory support or support for a single organ/system failure. Level 1 being 'ward fit' care.

This approach has been rationalised for the purposes of staffing establishments and capacity planning.

The traditional level 3 care bed is now rated as 1 and level 2 or HDU style care being rated as 0.5. This means a critical care unit can flex both bed base and staffing accordingly.

The trust has provision for critical care beds on both sites. Both sites have a capacity equivalent to a dependency score of 7, with both units having physical capacity for 9 beds each. Both units have

a shift leader or coordinator who is supervisory, with a unit manager providing overarching supervision and support Monday to Friday as part of their overall leadership role.

The ICS standards recommend that each Intensive Care Unit has its own dedicated Matron who holds the Intensive Care qualification. These posts are currently being recruited The nursing workforce involved in direct patient care are all Registered Nurses, with a small number of CSWs utilised for 'runner' activity and support direct patient care on an ad hoc basis.

The number of staff with formal critical care training has been a challenge to maintain to appropriate levels, due in part to Band 5s with the Critical Care Course seeking Band 6 posts in London trusts.

The Unit at TWH is currently running with 75% of the workforce either completed or due to complete this year. The Unit at Maidstone will achieve compliance with 50% of the workforce having completed the programme by the end of the academic year 14/15.

Critical Care Outreach is currently working towards 24/7 provision. Recruitment is well underway for additional staff, with less than 2 wte still to be recruited to. Interview date has been set to recruit to these final posts.

Recommendation: *There are currently no recommendations for further investment in staffing*

Accident & Emergency

The underpinning approach for setting safe staffing levels within the A&E is primarily Professional Judgement aligned to capacity and demand modelling.

Draft Guidance was issued by NICE in December 2014 for consultation. The Trust has been directly involved with the consultation process.

The RCN Baseline Emergency Staffing Tool (2013) was trialled with limited success. The tool is data input heavy requiring review of each patient in the department every hour. The new clinical guideline under consultation from NICE gives more pragmatic approach based on average attendance data, department geography and wider patient flow including rapid assessment.

Both units have the principles of rapid assessment process in place. Work is being undertaken at the TWH site to provide dedicated space for this, similar to the Urgent Medical Ambulatory Care Unit at Maidstone.

The department has benefited investment in staff in the last couple of years. In order to meet the potential recommendations from the NICE guidance and to fully implement the rapid assessment model, a further investment is likely to be required. This investment has included paediatric trained nurses being recruited to at both departments with good success.

Recommendations: Consider the implications of the draft NICE clinical guideline and include in business planning.

Paediatrics

The majority of paediatric care is provided on the Tunbridge Wells Hospital site, with a day care/assessment unit at Maidstone Hospital.

Riverbank provides a 5 day service on the Maidstone site with a bed capacity of 13. The unit provides an assessment service to A&E and day case care. There is planned day case care for three days a week and during this time an extra RN (Child) is on duty.

The RN to child ratio is 1:4 and is in line with national recommendations for 1:4 for 2yrs of age and above. The ratio for children under 2 yrs. is 1:3.

Hedgehog provides a full range of inpatient paediatric care including 2 HDU beds. The total bed base is 23. There are 2 Band 7 Ward managers who provide managerial support and professional leadership to Hedgehog, Woodlands and Riverbank. Hedgehog staff are combined on the rota to provide cover across both Hedgehog and Woodlands as Woodlands will flex in-patient beds according to emergency care demands.

Woodlands provide 10 beds for day case activity 3 days per week. This includes a pre-assessment service.

Woodlands also provide an assessment service through 5 rooms. Woodlands receives direct referrals from General Practitioners, ward follow up attenders, chemotherapy outpatient service and ambulatory care.

Based on current safety performance the current ratio of 1:4.6 is considered to be safe.

The unit is now has minimal vacancies, of the 6.35 wte Band 5 vacancies 3wte are 'turn-over' posts – that is posts that are recruited to in order to match known and predicted staff turn-over. There is a rolling advert and recruitment process in place.

Neonatal Unit – provides level 2 neonatal intensive care. If a neonate requires extended ventilation or is of low gestation s/he will be transferred to a level 3 unit.

The unit is staffed and budgeted for 18 cots; however this is often flexed upwards due to lack of capacity across the network. The RN to Cot ratio is currently in line with recommendations as set out by the British Association of Perinatal Medicine. Bed base is determined by the Neonatal Network based on network capacity and staffing profile.

The shift coordinator is supervisory, however will take a case load when network pressures demand.

Overall paediatric staffing levels are adequate and vacancies are minimal to zero.

The key current risk in paediatric staffing is the escalation requirement for woodlands particularly out of hours.

The changes to A&E do not appear to have impacted significantly on the number of admissions to the unit. However the appointment of additional Paediatric Consultants will enable the Unit to provide a more responsive service and improve speed of treatment, transfer and/or discharge.

Escalation of in-patients into Woodlands does impact on overall activity and remains the Unit's greatest challenge. The Directorate are considering the potential of extending the opening hours of Woodlands as part of their business planning intentions.

This has previously been considered, however it is now part of a wider paediatric care pathway review

Recommendations: *there are no recommendations for change currently.*

Maternity

The methodology used for setting safe staffing levels for maternity services is based on Birth-rate Plus. NICE recently published draft clinical guidance for consultation; however, they have not, to date, confirmed which staffing model is recommended.

Midwifery staff rotate through the service to provide consistent cover, within a specific locality.

There are 3 ward manager type roles covering antenatal ward, labour ward and post-natal ward. One of these post-holders will take operational bed management responsibility for the maternity unit between 08.00 and 20.00.

Delivery suite coordinator is supervisory but will often take a case load. This role is staffed 24/7.

The ratio for midwife to woman in established labour is 1:1 which is met.

HDU (2 beds) require a ratio of 1:1 however the dependency is frequently such that this can be flexed either to cover labour ward or to cover HDU as appropriate.

Birth-rate Plus indicates an acuity and dependency ratio of 1:28.5 locally against a national benchmark of 1:28.

Acuity and dependency is recorded daily and staffing is flexed accordingly.

Ante-natal ward provides 17 beds plus 4 triage beds open 24/7

The staffing ratio for ante-natal 1:8.5

Post-natal ward provides care in 31 single rooms. The Unit has a 24% section rate meaning that potentially 1 in 4 women will require surgical nursing care.

The Post-natal ward shift coordinator is supervisory for 5 days.

The ratio based on 4 RMs for 31 beds is 1:7.5

Discharge is fully midwifery led, indicating a possible case for a ‘Discharge Midwife’ role.

Maidstone Birth Centre provides a midwifery led service in a ‘stand-alone’ building on the Maidstone site.

It is staffed by 2 RMs and 1 support worker 24/7.

Additional support is provided by the Community Midwifery team if a transfer to Tunbridge Wells is required. It should be noted the transfer rate for the Maidstone Birth Centre is lower than the national average.

Maidstone Fetal Assessment provides a Monday to Friday service between 08.00 and 17.00.

It is staffed by 3 RMs and 3 support workers.

Community Teams – the majority of the work in the community is ante-natal care with some home deliveries.

Midwives are aligned to GP practices, however all community care is provided by midwives.

The case loads for the community team is currently being reviewed. The national recommendation is 120 cases per midwife.

The national benchmark for midwife to woman ratio is 1:30. There is clause that allows for the inclusion of maternity support staff providing the ratio is maintained at 90/10 – that is 90% of the care is delivered by a Registered Midwife.

The midwife to woman ratio for the Trust is 1:32; however, if the 90/10 rule (as defined in Birth-rate Plus) is applied the ratio is 1:29.

The national recommendation for supervisor to midwives is 1:15. The Trust has a ratio of 1:12 however this will change for a period of time with the change in post-holder for the Head of Midwifery.

Recommendations: *there are no recommendations for change currently.*

The directorate is considering uplift as part of wider forward planning based on the projected increases in birth rates.

Out-patients Department; out-patient services are provided on both sites. The main OPD service is managed as a single service across both sites from a leadership and management perspective. In practice this means that both sites have a site specific establishment that is in line with national recommendations.

Both sites have a band 7 in post, and the RN to CSW ratios are in line with the 60/40 recommendation.

Nurse to consultant room ratio is 1:2 and there are no concerns expressed by the team in relation to this.

Recommendations: *there are no recommendations for change.*

8.0 Vacancy

The Trust has in place a Recruitment and Retention Strategy Group to oversee the recruitment of staff across all directorates. The group is co-chaired by the Chief Nurse and the Director of Workforce. International recruitment is planned with the first event taking place end of March 2015. The Trust has also held successful open days for registered nurses with more events planned.

Recruitment remains challenging but the last three months has seen a slight upturn in recruitment.

9.0 Temporary Staffing

In common with many other Trusts, there has been a significant increase in the number of requests for additional staff to support patients with cognitive impairment or high risk of falls.

The Trust has in place a policy and procedure for the booking of specials. This is currently the subject of internal audit to ensure that the application of the process is consistent.

Directorates have been tasked with considering alternative approaches to ‘specialing’. Initiatives such as the Dementia Key Worker/Activities Coordinator, changes to patterns of care delivery and use of schemes such as the Dementia Buddy Scheme are being explored.

Additional operational pressures over the last quarter have also had an impact on temporary staffing usage, with a peak of 100 additional beds open during the early part of January 2015. Temporary Staffing usage is monitored on a daily and weekly basis by the Directorate Matrons and reviewed subsequently by the Associate Directors of Nursing.

10.0 Conclusion

Overall staffing levels are meeting the needs our patients and provide safe levels of care.

Additional capacity or rapid changes in acuity bring short-term challenges, which are generally adequately managed.

Where there are recommendations for change, as detailed above, the Directorates are in the process of including in their final business plans supported by business cases for investment.

Appendix 1

Staffing Review by ward					Ratios		Nurse Sensitive Indicators (Q4)					Comments
Site	Ward	Budgeted Est. (wte)	Safe Staff (Acuity & Dependency) (wte)	Vacancy (wte)	RN:CSW	RN:Pt (E, L & N)	Pressure Ulcers (cat 2+)	Falls	Medication Errors	QuESTT	Nursing Care Complaints	
TCH	Stroke Rehab	20.19	19.62	2.0	60/40	1:4, 1:6, 1:6	0 >90 days	7	0	4	0	Revise shift calculator to reflect 1 long day shift rather than 2. no case for further investment currently
Maidstone	Pye Oliver	32.61	34.35	3.24	60/40	1:7. 1:7. 1:9	1	15	1	9	2	Pye relocating to Cornwallis at end of May 2015. Staffing adjusted accordingly to reflect RN:pt ratio and turn-over of patients. Skill mix altered by large numbers of newly qualified staff. Some saving from move to be reinvested in PDN role for 2 days per week to support newly qualified and address the loss of qualified mentors
Maidstone	Lord North	26.96	27.64	0	80/20	1:3.6, 1:4.5, 1:6	1	0	2	1	0	No recommendations for change
Maidstone	Mercer	30.15	38.09	4.0	67/33	1:6. 1:6, 1:8	0	17	1	5	0	No further recommendations for change; additional CSW at night and formalising Dementia Key Worker as recommended in Sept'15 included in directorate business planning
Maidstone	John Day	33.57	37.56	3.0	63/37	1:5, 1:6.5, 1:7	2	13	3	5	0	Moving to Pye Ward. Bed base increased by 2. No significant impact on staffing. Recommendation from Sept'14 to increase RN cover at night by 1 included in business planning.
TWH	Ward 21	45.03	44.56	6.23	66/34	1:5, 1:6, 1:6	3	18	1	7	0	Safe Staffing in line with budgeted establishment. Consider case for change for supporting NIV in context of changing approaches in care for patients with long term respiratory conditions, and to consider options to meet ICNARC and BTS recommendations
TWH	Gynae	20.46		2.09	70/30	1:5, 1;5, 1:6	0	6	0	6	0	Ward Manager does not have any supervisory/management time. The team cover Emergency Gynae Assessment Unit, which includes both 'bed base' and ward attenders (average 20/day) Support business intention for uplift of 3wte.
TWH	Short Stay Surgery	10.91	N/A	2.51	77/23	1:5	0	0	0	N/A		No dedicated Band 7 & for unit: Medication errors high risk, may not be captured. Patients often discharged from theatres – staff cross cover with Recovery to manage this. Need to consider benefits of aligning to Critical Care directorate
TWH	SAU	17.77	N/A	3.88	65/35	1:3, 1:3 1:4.5	0	1	0	N/A	0	Band 7 has no supervisory time. However has sole responsibility for unit. Surgical Coordinator based on unit . Band 6 currently on secondment to Short Stay Unit.
TWH	Ward 10	44.29	50.83	5.10	63/37	1:5, 1:5, 1:7.5	0	7	0	5	0	Variation in establishment and safe staffing requirements matched by the vacancy factor. Temporary staffing reliance higher at night as day has additional CSW for C.diff cohort if required. Need to consider remodelling within budget to increase at night. Shift skill mix following recent leavers (senior staff retiring).

Staffing Review by ward					Ratios		Nurse Sensitive Indicators (Q4)					Comments
Site	Ward	Budgeted Est. (wte)	Safe Staff (Acuity & Dependency) (wte)	Vacancy (wte)	RN:CSW	RN:Pt (E, L & N)	Pressure Ulcers (cat 2+)	Falls	Medication Errors	QuESTT	Nursing Care Complaints	
TWH	Ward 30	42.18	45.27	5.02	64/36	1:6. 1:5, !;8	1	31	1	7	0	Safe Staffing suggests a shortfall of 3 wte. There is a reliance on temporary staffing at night. Directorate are developing a case as part of business planning to increase CSW at night by 1 equating to 2.53
TWH	Ward 31	46.97	42.29	5.88	53/47	1:6, 1:6, 1:8	4	13	1	7	0	RN to CSW ratio skewed by the previous addition of an additional CSW to nights. The RN to patient ratio is acceptable. Significant improvements noted since additional CSW implements. Falls rate for March is zero. – No changes recommended.
TWH	ICU	49.64	N/A	0.25	91/9	1:1, 1:2 depending on acuity level	1	0	1	2	0	No recommendations for change
Maidstone	ICU	45.64	N/A	2.53	96/4	1:1, 1:2 depending on acuity level	0	0	1	2	0	No recommendations for change
TWH	OPD	21.36	N/A	0	60/40	1:per 2 consult rooms	0	2	0	N/A	0	No recommendations for change
Maidstone	OPD	13.3	N/A	1.35	68/32	1:per 2 consult rooms	0	1	1	N/A	0	No recommendations for change
TWH	A&E	71.31	N/A	7.0	82/18		0	19	5	N/A		Draft NICE guidance will supersede BEST tool. Unlikely to be complaint with NICE guidance when published. Likely to require further investment of 10 wte. Business planning intentions in progress for both establishment of rapid assessment and to achieve compliance with NICE guidance.
Maidstone	A&E	54.18	N/A	7.38	90/10		0	2	1	N/A		
Cross-site	Paediatrics	56.59	N/A	7.35	76/24	1:3 <2yrs 1:4> 2yrs		3	6	2		Combined rota to cover hedgehog, woodlands and riverbank. Over established currently on band 6s (3wte). Band 5s recruited to turnover so aim for 42.63 against est 39.63.
TWH	NNU	44.62	N/A	2.0	87/13	3 ICU cots, 8 HDU cots	0	0	1	4	0	Rn to cot ratio complaint with British Association of Perinatal Medicine (BAPM). Exception is when NNU is escalated.
Cross site	Maternity	243.45	N/A	12.04	90/10	1:32 (90/10 split moves to 1:29)	1	0	4	N/A		Roster combined to cover all aspects of maternity care. Midwives rotate to community. NICE draft guidelines not yet clear on which staffing model to recommend. Birth Rate Plus ratio is currently 1:32, if maternity support worker included then ratio is 1:29. Supervisor ratio is 1:12 against standard of 1:15. Business Planning intentions include up lift for project increase in births to maintain 1:1 care established labour and ratio at 1:30.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - April 2015

4-15	**Update on the Trust's 2015/16 planning submissions (incl. budget and capital plan)**	**Director of Finance**

The report updates the Board on the development of Trust budgets for 2015/16

- The draft financial plan delivers a deficit of £13.4m (unchanged from the March report)
- The report reviews the TDA plan submission with commentary. The submission and this report also include detail over planned workforce levels. A short update on Directorate budgets that were in draft form at the time the submission was made.
- The final submission is due on 14th May 2015 and the elements that will influence any change to the April submission for May are also highlighted in the report.

Which Committees have reviewed the information prior to Board submission?
- Finance Committee, 27/04/15

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
To discuss and note progress towards the final plan submission and to note and approve the changes made since the March meeting

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Update on the Trust's planning submissions (including budget and capital plan)

1. Purpose

1.1 This paper summarises the key detail of the Trust's draft 2015/16 plan as submitted on the 7th April and the key elements for the final plan submission to be posted on the 14th May. This paper includes commentary on the schedules submitted on April. The planning submission is made up of several different forms (TRU forms), this paper summarises each form and provides some narrative for the figures returned in each form.

1.2 The paper will explain any changes to the 2015/16 plan since its submission in April.

1.3 The paper will focus on the submissions and the Trust's internal plans for each division including subjective budgets for each Directorate.

2. Executive Summary

2.1 The following table represents a summarised view of the I&E schedules that were submitted to the TDA on the 7th April 2015.

Income and Expenditure	**£m**
Operating income	395.1
Operating expenditure	(390.8)
Financing costs (loan interest, PDC)	(19.6)
Retained surplus/(deficit)	**(15.2)**
Adjustments (including IFRIC 12 - PFI)	1.8
Adjusted retained surplus/(deficit)	**(13.4)**

Table 1- I&E summary of plan submitted in April

2.2 The plan is risk rated in the submission as "red" as it shows a projected deficit and is also red for CoSR and showing a requirement for financial support through 2015/16 (see Para 4.9).

2.3 The level of deficit is the same as presented to the committee in March.
However, the details of the plan submitted did change slightly to take account the latest trend data from month 11 reports, technical accounting changes and a review of casemix using the ETO (Enhanced Tariff Option) tariff selected by the Trust. (The impacts of these changes are reflected in section 4.1 below).

2.3 Some further work will have to be done once the full price list and grouper is available.

2.4 The Board is asked to consider and approve that at this time the I&E position described in this paper is an accurate representation of the Trust's financial plan for 2015/16.

3. Changes between the Board and Finance Committee meetings in March and the plan submitted 7th April 2015

3.1.1 The key assumptions for the draft full submission were set out in the March Finance Committee and Board papers. Changes that were made to the plan after the Board but before submission are explained in the following section.

3.1.2 The changes to the April submission post the March board were:

- Impact of the Enhanced Tariff Option (ETO) – as more detail from Monitor regarding tariffs became available; no material change was identified from the ETO tariff, however some further work was done to review the case mix that was applied to the tariff.
- The case mix used to price with the new tariff was updated to more accurately include the impact of the winter case mix and maternity coding which increased the income expectation by £0.2m.
- Change in expenditure trends seen so far in Q4 was considered and an update to the expenditure plan (£0.6m). This was slightly offset by an increase in other income £0.2m seen in the same period.
- An adjustment to impairments to reflect a review of ICT assets has also increased operating costs by £0.5m, the impact to the bottom line is negated by an equal and opposite technical adjustment.
- A review of the capital asset base has resulted in a reduction to the expected levels of depreciation and PDC reducing financing costs by £0.4m.

3.1.3 Paragraph 4.1.2 and the TRU 64a and 64b schedules (Paragraphs 4.13 to 4.14.2) show the changes between the outturn for 2014/15 and the plan for 2015/16. The issues paragraph 3.1.2 will only affect the plan if they the outturn recurrently or have not already been built into the plan already. So the issues that do generate a change between years are:

- “Activity growth marginal contribution” in the bridge is affected by the £0.2m increase in casemix and the £0.6m increase in cost of delivery seen in Q4 giving a net deterioration between years of £0.4m.
- A review of the capital asset base has resulted in a reduction to the expected levels of depreciation and PDC reducing financing costs by £0.4m in 2015/16.

3.1.4 Even though these adjustments appear to net to a zero change between years it does reflect a reduction in cost efficiency in the delivery of patient services. In general an increase in nursing costs has been offset by a technical accounting adjustment resulting from the revaluation of capital assets. As depreciation is a non cash adjustment it should also be noted that these changes also represent an adverse pressure on cash balances.

4. The Financial Schedules Submitted

4.1 **TRU 1** – Summary Income and Expenditure
This form shows the high level income and expenditures for both the Trust's outturn for 2014/15 and the Trust's plan for 2015/16.

4.1.1 Extract from TRU 01

TRU 01 (extract)	2014/15	2015/16
	£m	£m
OPERATING SURPLUS/(DEFICIT)	6.1	4.4
Finance Costs (including interest on PFIs and Finance Leases)	(14.5)	(14.7)
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR	(8.3)	(10.3)
Dividends Payable on Public Dividend Capital (PDC)	(5.0)	(4.9)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR PER ACCOUNTS	**(13.3)**	**(15.2)**
IFRIC 12 adjustment including impairments	1.2	1.3
Impairments excluding IFRIC12 impairments	12.0	0.5
Donated/Government grant assets adjustment (include donation/grant receipts and depreciation of donated/grant funded assets)	0.1	(0.0)
Adjustments - other Net gains / (losses) on transfers by absorption	0.0	0.0
Adjusted Financial Performance Retained Surplus/(Deficit)	**0.0**	**(13.4)**

The issues that turn the breakeven in 2014/15 to a £13.4 deficit in 2015/16 are summarised in the table below (para 4.1.2) and described in a little more detail in paragraphs 4.13 and 4.14 (TRU 64a and 64b) but can be summarised at a high level as being as result of not including any NHS deficit funding in the 2015/16 I&E (part of the £22.5m adjustments figure in the table (para 4.1.2) below and the impact of CNST (part of the £13.2m in the table in para 4.1.2).

4.1.2 Bridge between 2014/15 and 2015/16

Summarised Bridge between years	£m
Adjusted Financial Performance Retained Surplus/(Deficit)	**0.0**
Adjustments to get to the underlying position (removing deficit support, changes to PFI funding, income provisions, asset sales and the revenue impact of changes in capital asset evaluation)	(22.5)
Price changes (including tariff, inflation and CNST)	(13.2)
CIPs	21.5
Activity changes	1.4
Changes in contracting rules	1.6
Service Changes	2.6
Increases in contingencies and specific cost pressures	(4.8)
Adjusted Financial Performance Retained Surplus/(Deficit)	**(13.4)**

This table is summarised view of the changes between the 2014/15 outturn and the 2015/16 plan.

4.1.3 The adjustments to get to the underlying position are:

- The assumed loss of deficit support funding of -£12m
- The reduction in PFI funding -£4.3m
- The non-recurrent benefit in 2014/15 of released SLA provisions reversing out -£2m
- The one off impact of the sale of Nurses Home in 2014/15 -£1.7m
- The reduction transitional support for Cancer tariffs -£2.9m
- The revaluation of capital assets reducing PDC and depreciation costs +£0.4m

4.1.4 Price changes are:

- The net tariff deflator (ETO) -£1.3m
- Pay inflation and incremental drift -£4.5m
- Non pay inflation -£3.1m
- Increase in CNST premium -£5.9m
- Non SLA income inflation +£1.6m

4.1.5 Other changes such as CIPs, activity changes (changes in cost due to changes in activity levels), changes in contracting rules (changes in thresholds +£0.9m and the ability to charge for new specialist outpatients in 2014/15 +£0.7m), service changes (contribution from service developments +£2.8m and -£0.2m for 7 day working) and increases in cost pressures and contingencies -£2.8m.

4.2. TRU 02 Statement of Financial Position (SoFP) or Balance Sheet

4.2.1 A summarised extract of the SoFP is shown below. The submission includes a balance sheet at outturn (31st March 2015) and for the end of each month through to 31st March 2016.

	YE 2014/15 £m	YE 2015/16 £m
Total Non Current Assets	**377.8**	**378.4**
Current Assets		
Inventories	6.2	6.2
Trade and Other Receivables	36.8	36.8
Cash and Cash Equivalents	3.5	1.0
Total Current Assets	**46.5**	**44.0**
Total Assets	**424.3**	**422.4**
Current Liabilities		
Trade and Other Payables	(37.0)	(39.0)
Provisions	(1.7)	(0.8)
Liabilities arising from PFIs / LIFT / Finance Leases	(4.8)	(4.8)
DH Capital Investment Loan	(2.2)	(2.4)
Total Current Liabilities	**(45.6)**	**(47.0)**
Net Current Assets/Liabilities	**0.9**	**(3.0)**
Total Assets Less Current Liabilities	**378.7**	**375.4**
Non-Current Liabilities		
Provisions	(1.8)	(1.4)
Liabilities arising from PFIs / LIFT / Finance Leases	(208.0)	(203.3)
DH Capital Investment Loan	(16.7)	(20.6)
Total Non-Current Liabilities	**(226.5)**	**(225.3)**
Total Assets Employed	**152.2**	**150.1**
Taxpayers Equity		
Public Dividend Capital	199.6	213.0
Retained Earnings reserve	(110.5)	(125.9)
Revaluation Reserve	63.1	63.1
Total Taxpayers Equity	**152.2**	**150.1**

4.2.2 The cash balance was higher than would be expected at 31st March 2015 due to an advance of funds from Health Education Kent, Surrey and Sussex of £2.5m that was not due until April 2015.

4.2.3 Non-Current Liabilities has reduced by £1.2m between years however this is due to two different movements that mutually compensate:

- The PFI liability has continued to reduce as yearly unitary payments are made, part of which repays the financing costs of the PFI.

- The balance of Capital investment loans will increase as the Trust is planning to apply for capital to support its capital asset investments for the year (Tunbridge Wells Radiotherapy Unit £2.5m and Tunbridge Wells Escalated Assessment Ward £4m), the balance is then reduced by the continued repayment of loan capital £2.1m, the impact of both can be seen in the Statement of Cash Flows.

4.3 TRU 04 Statement of Cash flows (SoCF)

4.3.1 The following is a summarised table of the SoCF submitted.

	YE 2014/15 £m	YE 2015/16 £m
Net Cash Inflow/(Outflow) from Operating Activities	**20.0**	**3.9**
Net Cash Inflow/(Outflow) from Investing Activities	**(14.0)**	**(19.3)**
Net Cash Inflow/(Outflow) from Operating Activities	**6.0**	**(15.4)**
Net Cash Inflow/(Outflow) from Financing Activities	**(3.8)**	**12.8**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**2.2**	**(2.5)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	1.3	3.5
Cash and Cash Equivalents (and Bank Overdraft) at the end of the period	**3.5**	**1.0**

4.3.2 The reduction in cash flow from operating activities is in main due to the loss of the £12m support funding assumed within the plan and changes in working capital that released cash in 2014/15 not repeating in 2015/16.

4.3.3 The increased cash outflows due to investments are from the planned investments in the new ward and Radiotherapy developments at Tunbridge Wells. £5m of cash inflow from financing is from a loan that would be required to support the Tunbridge Wells investments. The remaining cash inflow from financing activities from the assumed support funding the Trust will receive for 2014/15.

4.3.4 The Trust is not able to hold a year end cash balance of more than £1m.

4.4 TRU 05 Revenue from Patient Care Activities

4.4.1 This schedule breaks down the planned income of the Trust by customer source for both 2014/15 and 2015/16. The income is also analysed by month. The schedules TRU 70 and TRU 71 give more detail behind the CCG and NHS England income numbers.

4.4.2 This schedule does show what appears to be a switch in income from NHS England to CCGs. In fact this apparent switch is a result of a number of expected changes between years, for NHS England commissioners the main reductions are;

- Reduction in from NHSE for PFI (NHD2) (£4.2m)
- Reduction in Transitional support from the SCG (NHS England) (£2.9m)
- Release £1.7m brokerage from NHS England in 14/15 (will not repeat)
- £12m reduction from NHS England for NR Deficit funding
- £1.2m reduction in income from the SCG due to the ETO growth threshold.

For CCGS the following areas are expected to see increases in income.

- New and full year effects of service changes £8.5m
- Non Elective threshold £3.8m
- £1.6m A&E growth
- £4m cost of change funding

4.4.3 The changes associated with the HIS service hosted by the Trust is the main reason for the £3m reduction between years for other income.

4.4.4 Some more detail to explain the total movements between years is explained in paragraph 4.13 (TRU64a Source and Application of Funds for Income).

4.5 TRU 06 Operating Expenses

4.5.1 This schedule analyses a total £390.8m operating expenditure plan for 2015/16 broken down by expenditure type and comparing it to the outturns seen in 2014/15. Like the TRU 05 the expenditure plan is also broken down by month.

4.5.2 There is an overall reduction in expenditure between years of £2.9m. The movements in total are examined in paragraphs 4.14.1 to 4.14.3 (TRU 64b Source and Application of Funds for expenditure). The largest differences at expenditure type level are:

- £11.5m reduction in impairments
- £10.5m increase in costs recharged by NHS providers is due to the instigation of KPP
- £4m increase in other costs because of the KPP associated redundancies that may happen at the end of 2015/16.

4.6 TRU 14 Analysis of Impairments

4.6.1 This schedule shows the allocation of the expected £0.5m 2015/16 impairment for IT equipment and classifies it under the cause of normal losses from damage or use.

4.7 TRU 19 Provisions 2015/16

4.7.1 This schedule provides some analysis on the utilisation of provisions made up to and including 2015/16. The Trust expects to utilise £1.4m of the provisions in 2015/16 whilst making provision for £0.2m of new issues.

4.8 TRU 20 IFRIC 12

4.8.1 The schedule reflects the calculation the Trust makes to evaluate the impact of adopting IFRS accounting standards on the accounting for the PFI in the Trust's accounts. It analyses the difference between the on balance sheet accounting under IFRS with the previous off balance sheet accounting in order to determine the additional impact to the to the Trusts net costs. As NHS Trusts were not funded for the additional costs of the accounting change, the break even duty was altered to allow the exclusion of this additional impact as a technical adjustment.

4.9 TRU 54 Financial Risk Rating (Continuity of Risk Rating - CoSR)

4.9.1 The two financial indicators used in this schedule to measure CoSR have a mean score of 1.5 which rounds to 2. The CoSR measure has 4 categories 1 being the lowest (highest risk) and 4 the best (lowest risk) category.

4.9.2 The first of these measures is the liquidity. The liquidity ratio measures in days how long liquid assets in the Statement of Position (Balance Sheet) would be able to fund the operational expenditure. The Trusts has a negative value for liquid assets which gives a -9 days of expenditure cover which generates a CoSR score of 2. For the Trust to try and

achieve a CoSR score of 3 the liquidity ratio in days would have to be better than -7. In broad terms this would require a reduction in planned expenditure or an improvement in I&E of £2.1m.

4.9.3 The second CoSR measure is Capital Servicing Capacity for which the Trust scores 1 in the plan as stated. This measure is based on the ability of the Trust to generate funds through normal day to day operations in order to cover its financing costs. The plan gives the income for 2015/16 from normal operations as £22.7m (EBITDA without restructuring costs or income from interest received) and a financing cost of £26.7m (Dividend payments and debt repayments) which gives a ratio of less than 0.9. To achieve a 2 the Trust would have to increase the ratio to at least 1.25 and a score of 3 would require a ratio of 1.75. Therefore to score 2 earnings would need to increase by £10.7m and to score a 3 would require an increase of £24.1m.

4.9.4 As a mean score of 2.5 rounds to 3 (as long as neither individual score is below 2) the liquidity score (if financial support was available) would be the easiest metric to tip the Trust into an overall mean 3 CoSR score. Obviously both scores are influenced by the same underlying financial performance of the Trust and as the Trust remains in deficit year on year the liquidity ratio will deteriorate further moving the Trust further away from a green (3) CoSR score.

4.10 TRU 55 Capital Financing

4.10.1 Four tables are included in this schedule.

4.10.2 Annual Capital Cost Absorption Rate – this table defines the net relevant assets for the year and applies the absorption rate (3.5%) to check the valuation of PDC (Dividends on Public Dividend Capital) stated in the TRU 01. The Trust's stated value for PDC is consistent with this schedule.

4.10.3 External Financing Limit – states the external financing the Trust requires in order to meet its capital programme once the cash generated from normal operations is consumed but before the cost of any debt financing. This table values the funding required as £15.4m. If you compare this table with the TRU 04 (cash flow) you will see an assumption of external support funding £13.4m and loan for the proposed Radiotherapy and Ward developments at Tunbridge Wells will fill the gap in financing.

4.10.4 Capital Expenditure by Programme and Type – this summarises information on the Capital Expenditure Plan paragraph 4.11.3 (TRU 56) and includes other information on capital transactions such as the £1m impact of the potential sale of property.

4.10.5 IFRS Capital Expenditure IFRIC12 and Non IFRIC12 – the expected impact of the accounting changes as discussed in para 4.8.1.

4.11 TRU 56 Capital Project

4.11.1 This schedule contains a number of tables that describe what capital transactions the Trust is expecting over the next 5 years, when they will occur and what category they fall under (New Build, Maintenance etc.).

4.11.2 The planned capital expenditure in 2015/16 is £20.3m with funds being made available from the sale of property (£1m) and from donations £0.2m.

4.11.3 The table below gives a breakdown of the £20.3m Capital Programme for 2015/16.

2015/16 Capital Programme /£ms	Backlog	New Build	IT	Equipment	Cost of IFRIC 12 (PFI)	Totals
Estates Projects - Backlog maintenance	0.8	-	-	-	-	0.8
Ward refurb - Jon Saunders/John Day	3.2	-	-	-	-	3.2
TWH - Design variations/infrastructure	0.2	-	-	-	-	0.2
Estates Projects - other renewals	1.2	-	-	-	-	1.2
Kent Pathology Partnership	-	0.6	0.3	-	-	0.9
ICT - Infrastructure	-	-	0.8	-	-	0.8
ICT - Clinical System	-	-	0.8	-	-	0.8
ICT - Non-clinical systems	-	-	0.3	-	-	0.3
Core IT System Upgrade PAS	-	-	1.6	-	-	1.6
ICT - Inspire strategy	-	-	0.5	-	-	0.5
Linac replacement - Canterbury LA2	-	-	-	0.1	-	0.1
Trustwide equipment incl KPP	-	-	-	2.5	-	2.5
Inventory management cabinets/system	-	-	-	0.4	-	0.4
TWH - Lifecycle (IFRIC 12 PFI capital)	-	-	-	-	0.3	0.3
Donated Assets	-	-	-	0.2	-	0.2
TWH additional ward capacity	-	4.0	-	-	-	4.0
Accelerator - Bunkers & Equipment	-	2.5	-	-	-	2.5
Totals	**5.4**	**7.1**	**4.3**	**3.2**	**0.3**	**20.3**

4.12 TRU 63 Capital Cash Management Plan

4.12.1 This schedule explains how the Trust is intending to finance (provide cash) for its capital programme for the next five years. Focussing on 2015/16 the main sources of funding are:

- Internally generated funds – expenditure flagged as the non-cash spend of depreciation £14.4m
- The value of any assets sold in year (£1m property)
- Changes in capital creditors and debtors £0.2m
- Donations £0.2m
- Loans from the Department of Health £6.5m – the Trust was originally expecting to apply for funding under PDC but the Department has now stated that the Trust must apply for a Capital Investment Loan. The capital value for funding remains the same but an additional interest charge has had to be added to the Trust's revenue plan for 2015/16.

4.12.2 The Trust will apply for the loan as it will neither generate the cash from operations in year nor is able to hold sufficient cash from any historical surpluses it may have generated.

4.13 TRU 64a Source of Application of Funds – Source of Funds

4.13.1 This schedule explains the construction of the Trust's income plan by starting with the 14/15 outturn +/- known changes between years. The table below is a shorthand version of the schedule.

Source of funds	£m
2014/15 Outturn	**399.5**
Non recurrent deficit support funding	(12.0)
Income generated by CIPs started in 14/15	1.0
Changes caused by contract rule changes	3.8
14/15 new hospital development funding not repeating in 2015/16	(7.4)
Changes in Tariff (Inflation less efficiency)	(4.0)
Changes in price (non National Tariff areas)	1.1
Income from new CIP schemes	6.6
Income from Service Developments	1.6
Income from changes in activity	4.5
Impact from rule changes in National Tariff	3.8
Local price rules - SCG transitional funding	2.9
Commissioner funding for non recurrent restructuring	4.0
Income provisions set for 2015/16	(9.8)
Other	(0.7)
2015/16 Plan	**394.7**
Value of Donated Assets	0.3
Total Income (per para 2.1)	**395.1**

4.14 TRU 64b Source of Application of Funds – Application of Funds

4.14.1 This schedule works in the same fashion as the Source of Funds table but focuses on the expenditure plan and how it is constructed.

4.14.2 The following table is a summary of the TRU64b

Application of funds	£m
2014/15 Outturn per TRU 64b	**(399.5)**
FYE of CIPs schemes started in 14/15	2.3
14/15 non recurrent costs associated with resilience funding	2.3
Pensions cost pressure	(1.2)
Changes in price (inflation)	(7.1)
New CIP schemes	11.6
Cost of service developments and changes	(1.0)
Income from changes in activity	(1.4)
Impact of CNST change	(5.9)
Redundancy contingency	(4.0)
Other expenses including contingencies	(4.2)
Other	(0.0)
2015/16 Expenditure Plan per TRU 64b	**(408.2)**
Value of Donated Assets	0.4
IFRIC 12 adjustment including impairments	1.3
Impairments excluding IFRIC12 impairments	0.5
Total Expenditure (per Para 2.1)	**(410.4)**

4.14.3 The total expenditure ties to the Income and Expenditure summary in paragraph 2.2. Note the impact of CNST £5.9m, inflation and CIPs. The TRU 64b does not include the technical adjustments for IFRIC12 and donated Assets in its evaluation.

4.15 TRU 64c Surplus position and underlying position

4.15.1 This schedule starts with the outturn surplus of 14/15 (£0.0m) uses all the information held in forms TRU 64a and 64b and calculates the underlying £1.9m deficit for 2015/16.

4.15.2 The table below is a summarised version of the schedule. The schedule is produced from the details that are populated into schedules 64a and 64b.

Change type	£m	Notes
Surplus 2014/15	**0.0**	**As per TRU 01**
Add back non recurrent changes	(13.4)	The most significant reduction in surplus is the non recurrent nature of the deficit support funding, £12m 2014/15.
2014/15 recurrent base	**(13.4)**	
FYE effects from changes in 2014/15	1.8	
New CIPS 2015/16	18.1	The impact of FYE from 14/15 is included in the £1.8m FYE figure
Efficiency in tariff	(13.5)	
Commissioner support for QIPP	2.9	Transitional tariff change funding from SCG
Tariff inflation	9.4	
Tariff rule changes	4.9	Recurrent rule changes
Cost inflation	(14.2)	
Service changes	2.1	
Activity change	2.8	Recurrent changes
Increase in contingencies	(4.0)	
Other	1.0	
14/15 underlying deficit	**(1.9)**	

4.16 TRU 65 Efficiency Programme

4.16.1 This schedule breaks down the Trust's CIP programme, the table below summarises the schedule. It should be noted that even though the Trust has externally stated the CIP target as £21.5m that internally the Trust is still aiming to develop schemes to the value of the original planned level of £22.2m.

Length of Stay	Prior Year	Low Risk	Medium Risk	High Risk	Total New 2015/16 Schemes	Total Schemes
Length of Stay	0.0	0.0	1.8	0.0	1.8	**1.8**
Outpatient Productivity	0.0	0.5	0.0	0.0	0.5	**0.5**
Theatre Productivity	0.0	0.3	0.5	0.2	1.1	**1.1**
Nursing Productivity	0.6	0.1	0.3	0.0	0.5	**1.0**
Medical Productivity	0.3	0.0	1.3	0.0	1.3	**1.6**
Clinical Admin	0.0	0.4	0.0	0.0	0.4	**0.4**
Financial Management	0.0	0.0	2.0	0.0	2.0	**2.0**
Contract Management (Counting & Coding)	0.2	0.0	1.5	0.0	1.5	**1.7**
Contract Management (Service Devp)	0.2	0.0	2.1	0.0	2.1	**2.3**
Contract Management (Outsource Redn)	0.0	0.3	0.0	0.0	0.3	**0.3**
Contract Management (Local Tariff)	0.0	0.0	0.0	0.3	0.3	**0.3**
Contract Management (BPT)	0.1	0.9	0.0	0.0	0.9	**1.0**
Contract Management (Penalty Avoidance)	0.0	0.0	0.0	0.0	0.0	**0.0**
Contract Management (Commercial Income)	0.1	0.2	0.0	0.0	0.2	**0.3**
Procurement	0.4	1.2	0.0	0.0	1.2	**1.5**
Drugs	0.1	0.7	0.0	0.0	0.7	**0.8**
Back Office - Commercial Income	0.1	0.4	0.0	0.0	0.4	**0.5**
Back Office - Pay	0.4	0.0	1.6	0.0	1.6	**2.0**
Back Office - Procurement	0.5	1.3	0.0	0.0	1.3	**1.8**
PPU Income	0.3	0.1	0.0	0.0	0.1	**0.4**
CIP Totals	**3.4**	**6.5**	**11.1**	**0.5**	**18.1**	**21.5**
% of New Schemes		**36%**	**61%**	**3%**		

4.17 TRU 67 The Efficiency delivered 2014/15 and planned 2015/16

4.17.1 This schedule states the planned Trusts efficiency for 2015/16 of 4.3% and the delivered efficiency for 2014/15 as 5.6%.

4.17.2 The efficiency is calculated using the £18.1m of schemes that commence in 2015/16 compared to the £426.3m of planned expenditure (before efficiencies and £1.8m of technical IFRIC 12 costs).

4.17.3 The TRU 67 also reviews how the broader efficiencies in the tariff and guidance are reflected in the plan. The table below reflects the TRU 67 schedule. The table is based on what is reported in the plan but does not compare the efficiencies with a normalised position; it does not reflect the impact of the £12m of support in 2014/15.

Impact on Efficiency	£m	%	Notes
Efficiencies built into the plan			
Tariff Deflation	(13.5)	-3.2%	Impact of tariff deflator on income
Tariff Price changes not included elsewhere	1.1	0.3%	Funding from inflation charged to non NHS customers
Inflation in expense plan exceeds inflation in tariff	(4.7)	-1.1%	The £5.9m cost increase in CNST is the main driver of this shortfall.
Marginal Rate emergency	4.5	1.1%	Shows the reduction on the required efficiency flagged in the Tariff deflator due to the change NEL threshold rules.
Emergency readmission	(0.7)	-0.2%	Impact on readmission rules on Trust
Total efficiency from price	**(13.3)**	**-3.1%**	**Net impact of cost inflation and price changes built into tariff.**
Change in Surplus	**13.4**	**3.2%**	**Impact of movement in surplus post with no financial support**

4.18 TRU 70 2014/15 Income for Patient Care from NHS Commissioners

4.18.1 This schedule breaks down NHS patient care income that was earned in 2014/15. The following table is an extract from the schedule.

2014/15 INCOME (/£m)	ADMISSIONS			OUTPATIENTS					
	Elective Inpatients	Elective Day cases	Non Elective	1st	F/ up	A&E	Excl Drugs and Devices	Other	Total
Non-Contract Activity Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.6	2.6
Other CCGs (Individually less than £5 million)	0.6	0.9	1.7	0.5	0.6	0.3	0.1	0.0	4.8
NHS Dartford, Gravesham and Swanley CCG	0.3	0.6	0.5	0.4	0.6	0.1	0.3	0.8	3.6
NHS High Weald Lewes Havens CCG	1.6	2.2	7.5	1.7	1.8	0.9	0.8	4.4	20.9
NHS Medway CCG	0.9	2.0	1.3	1.6	2.6	0.4	1.1	2.3	12.2
NHS Swale CCG	0.5	1.0	0.7	0.5	0.8	0.1	0.5	1.3	5.5
NHS West Kent CCG	17.9	25.8	69.3	17.8	19.0	11.6	5.0	40.8	207.2
CCG Total	**21.8**	**32.3**	**81.0**	**22.6**	**25.3**	**13.6**	**7.9**	**52.4**	**256.9**
Non-Contract Activity Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	29.9	29.9
Other LATs (Individually less than £5 million)	0.0	0.1	0.1	1.4	0.4	0.0	0.6	0.1	2.7
Surrey and Sussex	1.0	12.5	2.0	0.9	2.8	0.0	15.6	20.8	55.4
Wessex	0.0	0.0	0.0	0.0	0.0	0.0	4.7	0.0	4.7
Other (NHS ENGLAND)	**1.0**	**12.6**	**2.0**	**2.4**	**3.2**	**0.0**	**20.8**	**50.7**	**92.8**
TOTAL	**22.8**	**44.9**	**83.0**	**24.9**	**28.5**	**13.6**	**28.7**	**103.1**	**349.6**

4.19 TRU 71 2015/16 Income for Patient Care from NHS commissioners

4.19.1 This schedule breaks down the 2015/16 planned income from NHS Commissioners. The following table is an extract of the TRU 71.

2015/16 INCOME (/£m)	ADMISSIONS			OUTPATIENTS					
	Elective Inpatients	Elective Day cases	Non Elective	1st	F/ up	A&E	Excl Drugs and Devices	Other	Total
Non-Contract Activity Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.9	2.9
Other CCGs (Individually less than £5 million)	0.7	0.9	2.0	0.5	0.7	0.4	0.1	5.2	10.5
NHS Dartford, Gravesham and Swanley CCG	0.3	0.6	0.6	0.4	0.6	0.1	0.4	1.0	3.9
NHS High Weald Lewes Havens CCG	1.6	2.2	7.9	1.8	1.8	1.1	0.8	3.4	20.7
NHS Medway CCG	1.0	2.0	1.5	1.6	2.7	0.5	1.1	2.6	13.0
NHS Swale CCG	0.5	1.0	0.7	0.7	1.0	0.2	0.5	1.2	5.6
CCG Total	**22.7**	**32.6**	**85.9**	**23.5**	**25.4**	**15.4**	**8.1**	**63.5**	**277.1**
Non-Contract Activity Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	12.0	12.0
Other Regions (Individually less than £5 million)	0.0	0.1	0.1	1.6	0.5	0.0	0.6	0.1	3.0
South East	0.8	11.5	1.4	0.8	2.8	0.0	16.1	17.0	50.4
Wessex	0.0	0.0	0.0	0.0	0.0	0.0	4.8	0.0	4.8
Other (NHS ENGLAND)	**0.8**	**11.6**	**1.6**	**2.4**	**3.3**	**0.0**	**21.5**	**29.1**	**70.2**
TOTAL	**23.6**	**44.2**	**87.4**	**25.8**	**28.7**	**15.4**	**29.6**	**92.6**	**347.3**

4.19.2 This schedule along with the TRU 70 gives more detail behind the figures in the schedule TRU 05 (see Para 4.4).

4.19.3 The increase in CCG income and reduction in NHS England income is explained in paragraph 4.4.2.

4.20 TRU COM1 Basic Commentary

4.20.1 The TRU COM schedule is a short commentary on the significant numbers and issues that are flagged within the plan return.

4.20.2 The following issues represent the main areas discussed in this schedule.

- The commentary stated that the Trust was in recovery and heading towards a surplus in 2017/18.
- Trust confirms it needs £13.4m of support as it goes through this period of deficit.
- The CoSR of 2 is as a result of the Trust's overall position and reflects its need for further funding.
- Outlined the support received in 2014/15 and the other sources of funding including the PFI taper support.
- Expenditure movements between 2014/15 and 2015/16 are as a result of KPP, the impairment of IT equipment and the CNST cost pressure.

4.21 Validations

4.21.1 There were no validations errors in the file submitted to the TDA. The TRU schedules check 88 individual potential problems. The checks range from addition of commentary where required to checking that the numbers across all schedules are consistent.

5 The Workforce Submission

5.1 Background

5.1.1 The Trust submits a separate workforce template that focuses upon the impact the plan has on both staff costs and staff numbers to accompany the full financial plan. It test's the Trust's plans by ensuring the Trust considers the impact the plan has on staffing and how limitations in human resources might impact the delivery of the plan.

5.2 The Schedules

5.2.1 The following schedules were submitted as part of the Whole time Equivalent (WTE) plan.

- WTE staffing forecast
- Pay Bill
- Bridge for Substantive Staff
- Bridge for Bank Staff
- Bridge for Agency Staff
- A summary Bridge to reflect all staff

5.2.2 The formulas in the return generated unavoidable validation errors. There were identified and fed back to the TDA. The Trust was advised that the issues were understood and that the return should be posted as planned. As with the finance return the WTE return was submitted per the timetable.

5.3 WTE staffing forecast

5.3.1 This schedule breaks down the changes by month and staff groups the number of WTEs the Trust plans to employ through 2015/16 and compares that figure with the closing staff numbers for 2014/15. The instigation of KPP is expected to significantly reduce the number of staff the Trust employs come the end of 2015/16.

TOTAL WTEs	2014/15	2015/16	Change	Change %
Substantive				
Medical	574.5	582.5	8.0	1.4%
Registered Nursing	1,392.4	1,447.3	54.8	3.9%
Scientific, Theraputic and Technical	666.3	569.1	(97.2)	-14.6%
Support to clinical staff	1,114.2	986.7	(127.5)	-11.4%
NHS Infrastructure Support	1,209.7	1,109.7	(100.0)	-8.3%
Others	0.0	3.1	3.1	
Substantive Totals	**4,957.1**	**4,698.4**	**(258.7)**	**-5.2%**

5.3.2 The schedule also looks at the numbers of Bank and Agency staff the Trust expects to employ. The following table is a summary of the one submitted to the TDA.

TOTAL WTEs	2014/15	2015/16	Change	Change %
Non Substantive				
Medical - Bank	0.0	0.0	0.0	0.0%
Non Medical Clinical Staff - Bank	244.3	241.9	(2.5)	-1.0%
Non Medical Non clinical Staff - Bank	42.3	42.1	(0.3)	-0.6%
Medical - Agency	33.4	28.3	(5.1)	0.0%
Non Medical Clinical Staff - Agency	144.6	98.1	(46.5)	-32.2%
Non Medical Non clinical Staff - Agency	48.6	36.1	(12.5)	-25.7%
Non Substantive Totals	**513.3**	**446.4**	**(66.9)**	**-13.0%**

5.3.3 The main reductions in agency numbers are from CIPS and service changes such as KPP. There are some agency increases expected due to meeting activity growth.

5.4 The Bridges

5.4.1 The bridges reflect the impact of the transfer of Pathology services to East Kent and the impact of CIPs. Activity growth and changes to service to meet 7 day working are also recorded as being drivers that increase WTE.

6 Directorate Budgets

6.1.1 The budgets for Directorates are nearing signoff. The table below is high-level view of the directorate budgets that parallel the overall submission made in April.

Current Draft Budget Positions / £m	SLA Income	Other Income	Expenditure	Resource Limit
Clinical Directorates				
Surgery	61.3	9.0	(38.9)	31.4
Critical Care	8.8	2.1	(34.0)	(23.0)
T&O	29.1	1.2	(15.6)	14.6
Emergency & Medical Services	87.6	8.1	(70.7)	25.1
Cancer & Haematology	36.5	21.2	(39.0)	18.7
Diagnostics	15.5	9.7	(33.2)	(8.1)
Women's & Sexual Health	30.7	0.7	(21.1)	10.2
Childrens	10.6	0.8	(10.7)	0.7
Sub Total Clinical Directorates	**280.0**	**52.8**	**(263.3)**	**69.6**
PPU	2.5	2.5	(4.4)	0.6
Sub Total Clinical Directorates inc PPU	**282.6**	**55.4**	**(267.7)**	**70.2**
Non Directorate				
Corporate	21.9	10.1	(114.2)	(82.2)
HIS	0.0	10.3	(10.3)	0.0
Reserves	14.5	0.4	(17.8)	(3.0)
Sub Total Clinical Directorates	**36.4**	**20.8**	**(142.4)**	**(85.2)**
TRUST TOTAL	**318.9**	**76.2**	**(410.1)**	**(15.0)**
Technical Impact				**1.6**
Breakeven Duty Position	**318.9**	**76.2**	**(410.1)**	**(13.4)**

6.1.2 Each directorate will have a signed “budget book” to measure financial performance against and to recognise the agreed financial objectives of the directorates (CIP targets, CIP schemes, service changes, workforce plans etc).

7 The May planning submission

7.1 Next steps

7.1.1 The draft full planning submission is on the 14th May. This will require the same full set of documents as submitted in April. The schedules will be updated for the following issues.

- To reflect the actual year end position and impact of m12 expenditure trends
- An updated KPP plan if available
- Impact of signed contracts
- Amended after any feedback from the TDA.
- Any other material emergent issue post 21st April.

7.1.2 The impact of the final accounting position will influence nearly all the schedules that are due to be submitted. The accounts are due to be submitted on Thursday 23rd April.

7.1.3 The KPP business case has been reviewed and the updated baselines (2014/15 outturn positions) will be agreed with East Kent and then adjusted into the plan. There is not expected to be any material changes from this process.

7.1.4 If available a tabled amendment will be put before the committee outlining the impact of any changes that are made after the closing date for papers.

8 Conclusion

The plan was submitted in its first full draft on time on the 7th April 2015. It will require updating before final submission on May 14th. This paper summarised the TDA submissions and the Board have been asked to consider the submission and make any observations or comments prior to approval.

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Trust Board Meeting - April 2015

4-16	2015/16 Contract update	Director of Finance

This report provides an update on the Trust 2015/16 contracts and contract negotiations.

Like for like the contracts that have been agreed for 15/16 are £14.8m higher than the values agreed in 2014/15.

The Trust has served an arbitration notice to NHS England (Specialist Services) and a process to agree a contract has therefore commenced and will complete by the 8th May 2015.

Which Committees have reviewed the information prior to Board submission?
- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
To discuss and note

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

1. Agreed contracts

1.1 The contract baseline has been agreed with following Commissioners

CCG	2015/16 contract value (£)	2014/15/contract value (£)
NHS West Kent	201,8	190.2
NHS Dartford, Gravesham & Swanley	2.9	2.9
NHS Medway	10.4	9.3
NHS Swale	4.5	4.3
NHS High Weald Lewes Havens	19.6**	17.8
NHS Eastbourne, Hailsham & Seaford	0.3**	0.3
NHS Hastings and Rother	1.0**	0.9

**This applies to the Sussex CCGs only. The numbers will be refreshed before contract signoff next week to include the impact of enhanced tariff option ETO on Sussex CCGs as well as activity relating MDTs and BPTs which are still being reviewed and negotiated by both parties.

The following has also been agreed for all Commissioners

- Local prices
- Commissioning intentions
- Movement from 2008/09 to 2011/12 for Non elective baseline (North Kent CCGs only)
- Local quality requirements
- CQUINs
- Information requirements

1.2 Outstanding areas of work

The following are yet to be agreed but are likely to go into contract long stop

- RTT (West Kent only)
- The Implications of the Short Stay Non-elective audit (West Kent Only)
- NCA activity to be added to the contract baseline (All CCGs)
- Local variation for Cystoscopy procedures (ALL CCGs)
- Referral plan (West Kent only)
- Data quality improvement plan (DQIP) (West Kent only)
- Service Development improvement plan (SDIP) (West Kent only)

2. NHS England (specialised services)

The Trust has served an arbitration notice for its contract with NHS England for specialised services. The notice was submitted on the 17 April in line with the national timetable in Appendix 1 below.

The major area of disagreement is the treatment of the £5.8m of transitional funding in the calculation of the stated baseline value. (The value over which, any activity will be subject to a marginal tariff). While the Trust's view is that the transition support should be included, NHS England view is the opposite. The financial implication this dispute is c.£1.3m.

Appendix 1: Arbitration timetable

Timetable item	Revised timetable
Entry into arbitration where contracts not signed; and submission of Dispute Resolution Process paperwork	17 April, Noon
NHS Trusts* / specialised commissioners which have not signed contracts required to submit a joint statement explaining the action they will jointly take to ensure contracts are signed by Monday, 27 April at 9.00 am	20 April
Automatic entry into arbitration where specialised commissioning contracts are not signed. Paperwork will need to be submitted as described in the dispute resolution process guidance. Paperwork submitted after this deadline will not be considered.	27 April (9.00am)
Independent panel arbitration panel meets	30 April
Letters to all parties confirming outcome of Arbitration decision	8 May

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Trust Board meeting – April 2015

4-17	**Summary report from the Quality & Safety Committee meeting, 13/04/15**	**Committee Chair (Non-Executive Director)**

A Quality & Safety Committee 'deep dive' meeting was held on 13th April 2015 and covered the following issues:

- An analysis of **Urology Cancer referrals** was discussed, and it was agreed to undertake further analysis of such referrals received by the Trust, in the context of the totality of such referrals made via local Clinical Commissioning Groups
- Representatives of Capsticks Solicitors LLP attended for this item, which discussed the outcome of their recent **Clinical Governance Review** (which was commissioned by the Trust following the issues raised from the Invited Review from the Royal College of Surgeons). The Committee was apprised of the Trust's response to the Capsticks review, and the changes that had taken place at the Trust, including the appointment of new Clinical Director for Surgery, and a new Clinical Lead for Cancer. It was agreed that the Medical Director, Chief Nurse, and Chairman of the Trust Board should liaise, to consider the most appropriate method of enabling a Trust Board discussion of the "Trust Quality Self Assessment" contained within the Capsticks' "Clinical Governance Review" report
- The Chief Nurse and Associate Director of Governance, Quality and Patient Safety provided an update on the Plans to report on progress with the **Quality Improvement Plan (QIP)** developed in response to the findings from the CQC's inspection in October 2014. Suggestions regarding the format of the Assurance Reports that would be provided to the Trust Management Executive and Trust Board were made, and it was agreed to introduce a 'RAGB' rating system, to assist in making the status of such progress clear.
- The External Adviser that the Trust has engaged to undertake a review of the Trust's Clinical Governance arrangements attended the meeting, to give her view of the **Principles of Culture and Good Governance** that will be used to form the basis of her review. It was suggested that it may be appropriate for the Adviser to give a presentation to the Committee in 6 months' time, after she had obtained a more considered view of the Trust.
- It was also agreed that **the focus of the next 'deep dive' meeting, on 10th June**, will be "Learning outcomes from upheld complaints"; and either "Review of the Mortality Review Group" or "Review of Multidisciplinary Team (MDT) meetings" (it was agreed that the Medical Director, Chief Nurse and Trust Secretary would liaise to determine which should be selected). It was also agreed that "Review of Pharmacy"; "Review of discharge arrangements"; and "Review of the plans for 7-day working" should be scheduled as items for review at future Quality & Safety Committee 'deep dive' meetings

Which Committees have reviewed the information prior to Board submission?
- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
- Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

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Trust Board meeting – April 2015

4-18	**Summary of the Trust Management Executive (TME) meeting, 15/04/15**	**Chief Executive**

The TME met on 15th April 2015. The key points from the meeting were as follows:

- The Committee's **revised Terms of Reference** (ToR) were approved. The key changes were:
  - The removal of the label of the "…designated integrated risk management committee of the Trust", in recognition that several of the Trust's committees have a role in risk management;
  - The status of the committee was made clear, following the Trust Board's determination in November 2014 that the TME should not be a sub-committee of the Board
  - An "Emergency powers and urgent decisions" section was added (which affords greater flexibility in the committee's functioning)
- The **Directorate reports** highlighted the following:
  - There had been a very good response to the advertisements for the four newly-created Consultant Emergency Paediatrician posts
  - The Committee was informed of the action being taken to address some identified problems in the reporting of Histopathology results; and some delays in the care of treatment of patients under the care of the Surgery Directorate
  - The implementation of Chemotherapy e-prescribing would be delayed by 6 weeks, to enable the outstanding concerns of NHS England's Clinical Reference Group to be satisfied
- The latest **performance, for month 12**, 2014/15 was reported. It was noted that the year-end performance on the A&E 4-hour waiting time target was 92%, but also that the Trust achieved the Department of Health objective of no more than 40 Clostridium difficile cases, and had a total of 28 cases for the year, which was 7 cases (20%) below the 2013/14 out-turn.
- The Chief Nurse provided an update on the Plans to report on progress with **the Quality Improvement Plan** developed in response to the findings from the CQC's inspection
- The Chief Operating Officer gave an update on the plans for the **Ward Development at Tunbridge Wells Hospital**. It was noted that drawings of the two options for configuration of the new Ward had been circulated for comment, and that it was intended to make a decision on such options at the TME in May 2015 (duly informed by discussions at the Clinical Operations and Delivery Group and Clinical Directors' meeting)
- The Medical Director gave an update on the developments with the **Clinical Excellence Awards**, and ideas for improvements to the local element of the Awards were discussed
- The Director of Finance informed the Committee on the development of the **2015/16 planning submissions**, and **changes to the NHS standard contract for 2015/16**
- The **recently-approved business cases** were noted
- The draft **Annual Governance Statement for 2014/15** was reviewed and agreed
- An update on the **Internal Audit reviews** within the 2014/15 plan was received
- The treatment of **'red-rated' risks** on the Trust Risk Register was discussed, and it was agreed that further review of risks be undertaken by Directorates, to enable the TME to consider the red-rated risks that remain, in June 2015
- Updates were received on the work of the **TME's sub-committees** (Capital meetings; Health & Safety Committee, Information Governance Committee, Policy Ratification Committee and the Clinical Operations and Delivery Group). The latter included the timeline for the John Day / Jonathan Saunders Ward redevelopment

Which Committees have reviewed the information prior to Board submission?
N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

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Trust Board meeting – April 2015

4-20	Revised Terms of Reference for the Patient Experience Committee	Committee Chair (Non-Executive Director)

The March 2015 Board received details of proposed changes to the form and function of the Patient Experience Committee. The Board agreed in principle with the proposed changes, and requested that the revised Terms of Reference (ToR) be submitted to the Trust Board in April 2015, for approval (i.e. rather than have agreed at the Patient Experience Committee beforehand).

The revised ToR are therefore enclosed, for review and approval. The format of the ToR has been updated, to reflect the Trust's standard format for the ToR of Board sub-committees, but the key changes to the content are as follows:

- The membership from the Trust has been revised and reduced
- The external membership has been re-labelled and clarified (although once the ToR are approved, a review of the current individual external members will be will be undertaken, to determine which of them will continue their membership)
- The standing items that the Committee should cover have been clarified, and reports from external members of the Committee has been formalised
- A duty to review the work being undertaken by Clinical Directorates in relation to the work they are undertaking regarding Patient Experience has been added
- The link with the Quality & Safety Committee has been made more formal
- An "Emergency powers and urgent decisions" section has been added (as is common with Board sub-committees)

The frequency of the meeting has been left unchanged for the time being. Although it had been proposed to increase the frequency to every two months, to provide more time for the Committee, feedback from existing members of the Committee has been received, pointing out that the same aim could be achieved by extending the length of existing meetings (to three hours), which would negate the need for external members of the Committee to make additional trips to the Trust. This will however be reviewed during 2015.

The Board is asked to pay particular attention to the proposed membership from the Trust.

A „clean' version of the revised ToR is enclosed, along with a „track changes' version, which shows the specific proposed revisions.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Approval

[1] All information received by the Board should pass at least one of the tests from „The Intelligent Board' & „Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
NHS Trust

PATIENT EXPERIENCE COMMITTEE

TERMS OF REFERENCE

1. Purpose

The Committee's purpose is to

1. Present the patient and public perception of the services delivered by Maidstone and Tunbridge Wells NHS Trust, and
2. Monitor any aspect of patient experience, on behalf of the Trust Board (or at the request of any Board sub-committee or other relevant Trust committee)

2. Membership

From the Trust:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Chief Nurse
- Director of Finance
- Deputy Chief Nurse
- Associate Director for Quality, Governance & Patient Safety
- Patient Experience Matron (x2)
- Complaints & PALS Manager

External to the Trust:

- Public representatives from the Trust's catchment area
- Representatives from patient and carer support groups within the Trust's catchment area
- Representative from Healthwatch Kent (1)
- Representative from the local Independent Health Complaints Advocacy service (1)
- Representative from the League of Friends of the Maidstone Hospital (1)
- Representative from the League of Friends of Tunbridge Wells Hospital (1)

3. Attendance and quorum

The Committee will be quorate when 4 members from the Trust, including 1 Non-Executive Director, and 4 members external to the Trust are present. Members may request a deputy to attend meetings in their place providing. Such a deputy will count towards the quorum.

All other Non-Executive Directors (including the Chairman of the Trust Board) and Executive Directors are welcome to attend any meeting of the Committee.

A representative from the „Doctors in training' (junior doctor) at the Trust will be invited to attend each meeting, and provide a report on patient experience-related matters relevant to their role.

A representative from West Kent Clinical Commissioning Group (CCG) will be invited to attend each meeting.

The Chair/s of the Patient Experience Committee's sub-committees will be invited to attend certain meetings, to provide a report on the sub-committee's activity.

The Committee Chair may also invite others to attend, as required, to meet the objectives of the Committee

4. Frequency of meetings

Meetings will be generally held quarterly.

Additional meetings will be scheduled as necessary at the request of the Chair.

5. Duties

- To positively promote the Trust's partnership with its patients and public
- To provide the perspective of patients and the public and to present the patients' and public's perception of the Trust's services
- To oversee the development of patient information within the Trust, via the Patient Information Leaflet Group (PILG)
- To contribute to the development of Trust Policies and procedures, in so far as they relate to patient experience
- To advise on priorities for patient surveys and on the methods for obtaining local patient feedback
- To act as the primary forum by which the Trust will involve and consult with its patients and public on:
  - The planning of the provision of its services
  - Proposals for changes in the way those services are provided, and
  - Significant decisions that affect the operation of those services
- To monitor (via the receipt of reports) the following subjects:
  - Findings from the national NHS patient surveys (along with a response)
  - Friends and Family Test findings (and response, if required)
  - Findings from local patient surveys
  - Findings from relevant Healthwatch Kent „Enter & View' visits (with a response, if relevant)
  - Comments from NHS Choices/'My NHS', and Social Media
  - Complaints information
  - PALS contacts information
  - Progress against the "Patient Experience" priorities in the Trust's Quality Accounts
  - Patient experience-related findings from Patient-led Assessments of the Care Environment (PLACE)
  - Patient experience-related findings from Care Assurance Audits (including reports from external members of the Committee)
- To review the work being undertaken by Clinical Directorates in relation to patient experience

6. Parent committees and reporting procedure

The Patient Experience Committee is a sub-committee of the Trust Board. The Committee Chairman will report its activities to the next Trust Board meeting following each Patient Experience Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported by Executive and Non-Executive members to each meeting of the Committee, by exception.

The Committee's relationship with the Quality & Safety Committee is covered separately, below.

7. Sub-committees and reporting procedure

The following sub-committees will report to the Patient Experience Committee through their respective chairs or representatives following each meeting:

- Patient Information Leaflet Group (PILG)

The frequency of reporting will depend on the frequency of each of the sub-committee.

8. Quality & Safety Committee

The Quality & Safety Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request

that the Quality & Safety Committee undertake a review of a particular subject, and provide a report.

The Patient Experience Committee should also receive a summary report of the work undertaken by the Quality & Safety Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality & Safety Committee to the Trust Board should be used for the purpose. Similarly, a summary report of the Patient Experience Committee will be submitted to the Quality & Safety Committee.

9. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda
- The meeting minutes and the action log

10. Emergency powers and urgent decisions

The powers and authority of the Patient Experience Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least one Executive Director member. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Patient Experience Committee, for formal ratification.

11. Review

The Terms of Reference of the Committee will be agreed by the Patient Experience Committee and approved by the Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

History

- Terms of Reference (amended) agreed by the Patient Experience Committee, 14th October 2009
- Terms of Reference (amended) agreed by the Patient Experience Committee, 4th October 2010
- Terms of Reference (amended) approved by the Patient Experience Committee, 3rd October 2011
- Terms of Reference (amended) agreed by the Patient Experience Committee, 6th February 2012
- Terms of Reference (amended) approved by Patient Experience Committee, 7th March 2013
- Terms of Reference (amended) approved by the Trust Board, 29th April 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

~~Terms of Reference~~

~~MAIDSTONE & TUNBRIDGE WELLS NHS TRUST~~

PATIENT EXPERIENCE COMMITTEE

~~Constitution and~~ **TERMS OF REFERENCE**

~~1. Constitution~~Authority

~~The Board has constituted a sub-committee of the Board to be known as the Patient Experience Committee. It is constituted at the request of the Trust Board to present the patient and public perception of services.~~

1. Purpose

The Committee's purpose is to

1. Present the patient and public perception of the services delivered by Maidstone and Tunbridge Wells NHS Trust, and
2. Monitor any aspect of patient experience, on behalf of the Trust Board (or at the request of any Board sub-committee or other relevant Trust committee)

2. ~~3~~2. Membership

From the Trust:

~~The membership of the Patient Experience Committee is as follows:~~

- ~~•~~ Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
  ~~AND – Non-executive Director~~
- Chief Nurse
- Director of Finance
- Deputy Chief Nurse

~~Director of Nursing - (Deputy Chair)~~
~~Medical Director~~

- Associate Director for Quality, Governance & Patient Safety ~~Head of Quality & Governance~~
- Patient Experience Matrons (x2)

~~Heads of Nursing~~
~~Directorate Representative - Matron~~
~~Communications Representative~~
~~Head of Information Governance~~
~~Head of Facilities~~

- ~~Junior Doctor~~
- ~~Patient Safety Team Representative~~

- Complaints & PALS Manager

External to the Trust:

- Public representatives from the Trust's catchment area ~~Members recruited from the local community~~
- Representatives from patient and carer support groups within the Trust's catchment area
- Representative from Healthwatch Kent (1)
- Representative from the local Independent Health Complaints Advocacy service (1)

- Representative from the League of Friends of the Maidstone Hospital (1)
- Representative from the League of Friends of Tunbridge Wells Hospital (1)

~~43~~. 3. Attendance and quorum~~Quoracy~~

The Committee will be quorate when ~~four~~ 4 members from the Trust, including 1 Non-Executive Director, and ~~four~~ 4 members external to the Trust ~~from the local community~~ are ~~in attendance~~present. Members may request a deputy to attend meetings in their place ~~providing the deputy has been agreed in advance by the Committee Chair~~. Such a deputy will count towards the quorum~~acy of the meeting~~.

~~4. Attendance~~

All other Non-Executive Directors (including the Chairman of the Trust Board) and Executive Directors are welcome to attend any meeting of the Committee.

~~In attendance:~~ A representative from the „Doctors in training' (junior doctor) at the Trust will be invited to attend each meeting, and provide a report on patient experience-related matters relevant to their role.
~~PALS Representative~~
~~Complaints Lead/Manager~~
A representative from West Kent Clinical Commissioning Group (CCG) will be invited to attend each meeting.

The Chair/s of the Patient Experience Committee's sub-committees will be invited to attend certain meetings, to provide a report on the sub-committee's activity.

The Committee Chair may also invite others to attend, as required, to meet the objectives of the Committee

~~By Invitation: Other members of staff may be invited to attend at the discretion of the Chair to speak to specific agenda items and issues~~

4. ~~—~~Frequency of m~~M~~eetings

Meetings will be generally held ~~The Patient Experience Committee shall meet~~ quarterly.

Additional meetings will be scheduled as necessary at the request of the Chair.

~~The Chair with the support of the Director of Nursing will:~~
- ~~Agree the Annual Work Programme~~
- ~~Set out the dates of planned meetings~~
- ~~Agree the key agenda items~~

~~The Committee shall be supported administratively by the Trust Management secretariat whose duties will include:~~
- ~~Call for papers from attendees and invitees at least 2 weeks before a meeting~~
- ~~Collation and distribution of papers one week before the date of the meeting~~
- ~~Taking the minutes and circulation of draft minutes following the meeting.~~
- ~~Maintaining a record of meeting papers and minutes as a corporate file for the Trust.~~

~~6. Reporting~~

~~The PILG Committee reports to the Patient Experience Committee through the Chairs or representative following each meeting.~~

~~The Patient Experience Committee is a sub-committee of the Trust Board. The Committee Chair will update the Board on the work of the Committee. The Committee Chair will provide a formal report to the Board on an annual basis.~~

~~5~~7~~6~~. Duties~~Terms of Reference~~

- To positively promote the Trust's partnership with its patients and public ~~partnership by valuing the contribution of each Panel Member~~.
- To provide the perspective of patients and the public and to present the patients' and public's perception of the Trust's services ~~within the Trust at Trust Committees~~.
- To oversee the development of patient information within the Trust, via the ~~liaise with~~ Patient Information ~~& Letter~~ Leaflet Group~~s~~ (PILG) ~~regarding key patient information concerns and to support and influence the development of patient information within the Trust.~~
- To contribute to ~~become involved in and influence~~ the development of Trust Policies and procedures, in so far as they relate to patient experience~~as they develop and change~~.
- To act as the primary forum by which the Trust will involve and consult with its patients and public on:
  - the planning of the provision of its services
  - proposals for changes in the way those services are provided, and
  - significant decisions that affect the operation of those services ~~develop a group of individuals of diverse backgrounds from whom the Trust can seek input in respect to service or policy change.~~
- To advise on ~~work in partnership with the Trust in determining~~ priorities for patient surveys and on the methods for obtaining local patient feedback ~~methods~~.
- ~~To consider and review the findings of national surveys to oversee the improvements against the in patient survey action plan.~~
- ~~To provide an arena for Patient Experience Committee Members to meet members of the Trust.~~
- ~~To contribute to an annual report to the Trust Board on the development ***and implementation*** of the Trust's Patient and Public Partnership strategy.~~
- ~~The Patient Experience Committee will undertake a self-assessment at least annually and be subject to audit against these approved Terms of Reference and agreed Key Performance Indicators by Internal Audit who will report to the Board. The Board will review the audit recommendations and take appropriate action.~~
- To monitor (via the receipt of reports) the following subjects
  - Findings from the national NHS patient surveys (along with a response)
  - Friends and Family Test findings (and response, if required)
  - Findings from local patient surveys
  - Findings from relevant Healthwatch Kent 'Enter & View' visits (with a response, if relevant)
  - Comments from NHS Choices/'My NHS', and Social Media (Facebook, Twitter etc.)
  - Complaints information
  - PALS contacts information
  - Progress against the "Patient Experience" priorities in the Trust's Quality Accounts
  - Patient experience-related findings from Patient-led Assessments of the Care Environment (PLACE)

- Patient experience-related findings from Care Assurance Audits (including reports from external members of the Committee)

- To review the work being undertaken by Clinical Directorates in relation to patient experience

6. Parent committees and reporting procedure

The Patient Experience Committee is a sub-committee of the Trust Board. The Committee Chairman will report its activities to the next Trust Board meeting following each Patient Experience Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported by Executive and Non-Executive Director members to each meeting of the Committee, by exception.

The Committee's relationship with the Quality & Safety Committee is covered separately, below.

7. Sub-committees and reporting procedure

The following sub-committees will report to the Patient Experience Committee through their respective chairs or representatives following each meeting. The frequency of reporting will depend on the frequency of each of the sub-committees:

- Patient Information Leaflet Group (PILG)

~~7. Reporting~~

~~The Patient Experience Committee is a sub-committee of the Trust Board. The Committee Chair will update the Board on the work of the Committee. The Committee Chair will provide a formal report to the Board on an annual basis.~~

~~The PILG Committee reports to the Patient Experience Committee through the Chairs or representative following each meeting.~~

~~8. Audit~~

~~The Patient Experience Committee will undertake a self-assessment at least annually and be subject to audit against these approved Terms of Reference and agreed Key Performance Indicators by Internal Audit who will report to the Board. The Board will review the audit recommendations and take appropriate action.~~

~~9. Administration and Duties~~

~~The Chair with the support of the Director of Nursing will:~~

- ~~Agree the Annual Work Programme~~
- ~~Set out the dates of planned meetings~~
- ~~Agree the key agenda items~~

~~The Committee shall be supported administratively by the Trust Management secretariat whose duties will include:~~

- ~~Call for papers from attendees and invitees at least 2 weeks before a meeting~~
- ~~Collation and distribution of papers one week before the date of the meeting~~
- ~~Taking the minutes and circulation of draft minutes following the meeting.~~
- ~~Maintaining a record of meeting papers and minutes as a corporate file for the Trust.~~

8. Quality & Safety Committee

The Quality & Safety Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request

that the Quality & Safety Committee undertake a review of a particular subject, and provide a report.

The Patient Experience Committee should also receive a summary report of the work undertaken by the Quality & Safety Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality & Safety Committee to the Trust Board should be used for the purpose. Similarly, a summary report of the Patient Experience Committee will be submitted to the Quality & Safety Committee.

9. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda
- The meeting minutes and the action log

10. Emergency powers and urgent decisions

The powers and authority of the Patient Experience Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least one Executive Director member. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Patient Experience Committee, for formal ratification.

911~~10~~. Review ~~of Terms of Reference and Monitoring Compliance~~

The Terms of Reference of the Committee will be agreed by the Patient Experience Committee and approved by the Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

History

- Terms of Reference (amended) agreed by the Patient Experience Committee, 14th October 2009
- Terms of Reference (amended) agreed by the Patient Experience Committee, 4th October 2010
- Terms of Reference (amended) approved by the Patient Experience Committee, 3rd October 2011
- Terms of Reference (amended) agreed by the Patient Experience Committee, 6th February 2012
- Terms of Reference (amended) approved by Patient Experience Committee, 7th March 2013
- Terms of Reference (amended) approved by the Trust Board, 29th April 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – April 2015

4-21 Oversight Self-Certification, Month 12, 2014/15 — Trust Secretary

The enclosed schedule sets out the proposed oversight self-certification submission for month 12, based on performance as at 31st March. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of April (i.e. by 30th).

As Board members are aware, each month the Trust Board is required to self-assess against the questions contained in two self-certification documents under the TDA oversight process:

1. Monitor licence conditions; and
2. Board statements

The Trust is not required to provide supporting evidence (as listed in the "Evidence of Trust compliance" columns), and is just required to respond to each statement with "Yes" (i.e. compliant), "No" (i.e. not compliant) or "Risk" (i.e. at risk of non-compliance). If "not compliant" or "at risk of non-compliance" is selected, a commentary on the actions being taken, and a target date for completion (in dd/mm/yyyy format), is required in order for the submission to be made. The proposed self-assessment (and responses where required) for the latest submission are included in the compliance column. The "Evidence of Trust Compliance" document has incorporated the amendments agreed at previous Trust Board meetings.

In relation to the Monitor licence conditions, there are some items which, as an aspirant Foundation Trust, the Board does not need to consider at the present time. These will however need to be understood and implemented as part of the trajectory to submit a Foundation Trust (FT) application. It is proposed that, where appropriate, where the Trust continues to declare non-compliance, and that the date by which the Trust will become compliant should be listed as 31st March 2017.

The evidence has been refreshed and updated from that reviewed at the Board in March 2015. Additions are highlighted, whilst deletions are shown as ~~struckthrough~~. No change in compliant status is proposed from that agreed by the Board in March.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

The Board is asked to:

- Review the evidence presented to support the self-assessment (and amend if required); and
- Approve the self-assessment for the forthcoming submission to the TDA

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Oversight Self Certification – Monitor Licence Conditions applicable to aspirant Foundation Trusts

General conditions

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
G4 – Fit and proper persons as Governors and Directors No unfit persons – undischarged bankrupts – imprisoned during last 5 years – disqualified Directors	All Trust Directors are "fit and proper" persons; confirmed through appointment process. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were approved by Parliament on 6th November 2014. The Regulations introduced a new requirement that Directors (or equivalent) of health service bodies be "fit and proper persons". The Care Quality Commission (CQC) will be able to insist on the removal of Directors that fail this test. Specifically, Directors should not be "unfit", which equates to not being an undischarged bankrupt; not having sequestration awarded in respect of their estate; not being the subject of a bankruptcy restrictions order; not being a person to whom a moratorium period under a debt relief order applies; not having made a composition or arrangement with, or granted a trust deed for, creditors; not being included in the children's barred list or the adults' barred list; and not being prohibited, by or under any enactment, from holding their office or position, or from carrying on any regulated activities[2]. In addition Directors need to be "of good character"[3], and have the health, qualifications, skills and experience to undertake the role. Finally, Directors should not have "been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity…". This latter restriction enables a judgement that a person is not fit to be a Director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time (or working outside England). The Regulations apply to all Directors and "equivalents", which will include Executive Directors of NHS Trusts and Foundation Trusts. It is the responsibility of the provider and, in the case of NHS bodies, the chair, to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria. The Chair of a provider's board will need to confirm to the CQC that the fitness of all new Directors has been assessed in line with the new regulations; and declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role. The CQC may also ask the	Yes

[2] Regulated activities are listed in Schedule 1 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They are: 'Personal care'; 'Accommodation for persons who require nursing or personal care'; 'Accommodation for persons who require treatment for substance misuse'; 'Treatment of disease, disorder or injury'; 'Assessment or medical treatment for persons detained under the Mental Health Act 1983'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Management of supply of blood and blood-derived products etc'; 'Transport services, triage and medical advice provided remotely'; 'Maternity and midwifery services'; 'Termination of pregnancies'; 'Services in slimming clinics'; 'Nursing care'; and 'Family planning services'. Any provider carrying on any of these activities in England must register with the Care Quality Commission.

[3] In determining whether a Director is "of good character", consideration should be given as to whether the person has been convicted in the UK of any offence; or whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
	provider to check the fitness of existing Directors and provide the same assurance to them, where concerns about such Director come to the CQC's attention. Although the Regulations will not, strictly speaking, be applied retrospectively, the Trust will likely need to ensure current Board members meet the Regulations' requirements for being "fit and proper". A proposed approach to the new Regulations was approved at the December 2014 Trust Board, and implementation has commenced (DBS checks are currently being processed for all Board members).	
G5 – Having regard to Monitor guidance – guidance exists or is being developed on: ▪ Monitors enforcement ▪ Monitors collection of cost information ▪ Choice and competition ▪ Commissioners rules ▪ Integrated Care ▪ Risk Assessment ▪ Commissioner requested services ▪ Operation of the risk pool	Monitor guidance is at varying degrees of progress through the consultation process. Trust response: **As an aspirant Foundation Trust, the guidance has not yet been fully reviewed and embedded. However the Trust will receive a summary of Monitor guidance requirements so that it can ensure compliance at a time appropriate to its foundation trust application trajectory.**	No Compliant by 31/03/2017
G7 – Registration with the Care Quality Commission	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities at both main hospital sites: 'Treatment of disease, disorder or injury'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Maternity and midwifery services' and 'Family planning'. In addition, the Trust is registered to undertake 'Termination of pregnancies' at Tunbridge Wells Hospital.	Yes
G8 – Patient eligibility and selection criteria (for services and accepting referrals) ▪ Criteria are transparent ▪ Criteria are published	The Referral and Treatment Criteria (RATC) which apply from 1st April 2014 are published on the West Kent CCG website ("Kent and Medway clinical commissioning groups' (CCGs') [sic] schedule of policy statements for health care interventions, and referral and treatment criteria").	Yes

Pricing conditions

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
P1 – Recording of Information (about costs) to support the Monitor pricing function by the prompt submission of information	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor pricing condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory** An action plan is required to ensure readiness to comply with all Monitor Pricing conditions at the required time (the Director of Finance will be responsible for leading on this).	No Compliant by 31/03/2017
P2 – **Provision of information** to Monitor about the cost of service provision	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor information condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**	No Compliant by 31/03/2017
P3 – Assurance report on submissions to Monitor. To ensure that information is of high quality, Monitor may require Trusts to submit an assurance report	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor assurance reporting condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**	No Compliant by 31/03/2017
P4 – Compliance with the national tariff (or to agree local prices in line with rules contained in the National tariff)	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes
P5 – Constructive engagement concerning local tariff modifications The aim is to encourage local agreement between commissioners and providers where it is uneconomical to provide a service at national tariff; thereby minimising Monitors need to set a modified tariff.	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes

Competition conditions

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
C1 – Right of patients to make choices Providers must notify patients when they have a choice of provider, make information about services available, and not offer gifts/inducements for patient referrals. Choice would apply to both nationally determined and locally introduced patient choices of provider.	The Trust complies with the philosophy of patient choice, with regards to choice of provider. The Trust has not taken any actions to inhibit patient choice. The development of private patient services, the development of a birthing centre and the response to the KIMS private hospital are examples where the Trust has increased patient choice.	Yes
C2 – Competition Oversight Providers cannot enter into agreements which may prevent, restrict or distort competition (against the interests of healthcare users).	The Trust does not seek to inhibit competition.	Yes

Integrated care conditions

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
IC1 – Provision of Integrated Care Trusts are prohibited from doing anything that could be regarded as detrimental to enabling integrated care. Actions must be in the best interests of patients.	~~The Trust seeks to become an integrated care provider and is in discussion with the CCG about integration initiatives.~~ The Trust does nothing to inhibit integration and positively advocates it where integration is in the patient's best interests.	Yes

Oversight Self Certification – Board Statements

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
For clinical quality, that: 1. the Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	▪ The Trust's integrated performance dashboard is reviewed monthly and includes the TDA's "routine quality & governance indicators" ▪ A "Clinical Quality & Patient Safety Report" report is submitted to the Trust Board ▪ The Quality & Safety Committee, and its sub-committees, provides a focus on quality issues arising from Directorates. A summary of each Quality & Safety Committee meeting is reported to the Board ▪ The Patient Experience Committee provides a patient perspective and input ▪ The Chief Nurse, a Board member, is accountable for quality ▪ There are dedicated complaints and Serious Incidents (SI) management functions ▪ Ongoing conduct of Family and Friends Test is reported through the Trust performance dashboard ▪ Patient stories are heard at Trust Board meetings ▪ SI report summaries are circulated to all Board members ▪ Board member visits to wards and departments enable triangulation of quality and other performance indicators. Pairings of NED and Executive Board members, to further promote such visits, have now been issued. Board members also participate in the conduct of Care Assurance Audits ▪ Systems investment (e.g. Q-Pulse, Symbiotix, Dr Foster) supports effective quality information/data management ▪ Quality Accounts have been developed in liaison with stakeholders ▪ Quality Impact Assessments conducted on all CIP initiatives ▪ Priority of patient care reflected in Trust values & embedded in staff appraisal The independent assessment of the Trust's Quality Governance Framework has largely endorsed the Trust's self-assessment and gave a validated score of 3.5; an action plan has been drafted to	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	achieve further improvements. Further improvements include: - strengthening the processes through which learning is shared and embedded has been recognised, and - developing further benchmarks to support the assurance & target setting process ~~The latest CQC Intelligent Monitoring data was published by the CQC in December 2014. The Trust was not issued with a "Priority banding for inspection" because the Trust was "Recently Inspected". However, the overall risk score was 8 which approximately equates to a Band 4.~~ The final report of the Trust's inspection by the Care Quality Commission in October 2014 was published in February 2015, and confirms that Trust's overall rating as 'Requires Improvement'. A Quality Improvement Plan has been developed in response, and ~~was discussed at the February 2015 Trust Board~~ has been submitted to the CQC. It will be monitored via the Trust Management Executive and Trust Board.	
For clinical quality, that: 2. the board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities at both main hospital sites: 'Treatment of disease, disorder or injury'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Maternity and midwifery services'; and 'Family planning'. In addition, the Trust is registered to undertake 'Termination of pregnancies' at Tunbridge Wells Hospital. ~~A CQC inspection of Tunbridge Wells Hospital reported in January 2014 concluded 'moderate concerns' about the Management of Medicines and Staffing outcomes. Actions are underway to address the areas of concern identified by the inspection, and the latest position was reported to the Trust Management Executive on 17th September.~~ ~~A Care Quality Commission inspection of Maidstone Hospital was undertaken in February 2014. Actions are underway to address the areas of concern identified by the inspection, and the latest position was reported to the Trust Management Executive on 17th September.~~	Yes

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	The final report of the Trust's inspection by the Care Quality Commission in October 2014 was published in February 2015, and confirms that Trust's overall rating as 'Requires Improvement'. A Quality Improvement Plan has been developed in response, and ~~was discussed at the February 2015 Trust Board~~ has been submitted to the CQC. It will be monitored via the Trust Management Executive and Trust Board.	
For clinical quality, that: 3. the board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	The Medical Director is the responsible officer for medical practitioner revalidation. The Trust Board in May 2014 received the 2013/14 Annual Report from the Responsible Officer, and approved a 'statement of compliance' confirming that the Trust, as a designated body, was in compliance with the regulations governing appraisal and revalidation.	Yes
For finance, that: 4. the board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time	Trust response: The Trust reported a deficit for 2013/14 and the financial situation is under ongoing review with the TDA. The Trust was recently awarded £12m of non-recurrent funding by the TDA for 2014/15. The Trust continues to operate as a going concern, and the 2014/15 financial accounts are being prepared on this basis.	Yes
For governance, that 5. the board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times	The NTDA accountability framework aims to ensure that Trusts have a real focus on the quality of care provided. Under this framework, quality focus is achieved through: (i) Planning – the Trust conducts an annual process of service and budget planning and the Board reviews and agrees the IBP (ii) Oversight – the Trust participates fully in the oversight model (self-certification, review meetings) (iii) Escalation – The Trust welcomes support from the TDA and will cooperate fully with escalation decisions. The Trust, has fully engaged with a risk summit of performance issues (c.diff, surgical trainees, A&E) (iv) Development – the Trust will embrace the development model as appropriate. The Trust has committed to development programmes for (i) Board members; (ii) Executive team, (iii) Clinical Directors and (iv) General Managers/Matrons.	Yes

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	(v) Approvals – the Trust is fully engaged in the FT application process and is awaiting dialogue with the TDA on the timetable towards authorisation. Trust values and priorities mirror the TDA's underpinning principles: ▪ local accountability – e.g. liaison with CCGs, Patient Experience Committee, patient satisfaction monitoring, whistleblowing & complaints management ▪ openness and transparency – e.g. embedded in Trust value on respect; duty of candour in Board Code of Conduct; open approach to Public Board meetings (which now take place each month) and both external &, internal communications channels; a growing membership ▪ making better care easy to achieve – the Trust's stated priority, above all things, is the provision of high quality & safe care to patients (Patient First). ▪ an integrated approach to business – the Trust has adopted an integrated governance approach including an integrated performance dashboard.	
For governance, that: 6. all current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.	See 5 above. In addition: ▪ The Trust monitors performance each month in accordance with the TDA Quality and Governance indicators. A Board Assurance Framework and Board level risk register, supported by an overall Risk management Policy, are established and scrutinised by accountable Executive Directors ▪ Risks receive ongoing scrutiny and assurance ▪ Mitigating actions have agreed dates for delivery ▪ An annual Internal Audit plan is agreed and focuses on areas of key risk ▪ A professional Trust Secretary is employed ▪ A dedicated Risk Manager is employed ▪ The Trust fully participates in the TDA Oversight process ▪ The independent assessment of the BGAF & QGF was conducted in July 2013 and the positive results reported to the Trust Board in September 2013; a follow up review conducted in December 2103 re-affirmed the assessment.	Yes

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For governance, that: 7. the board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance	See 6 above. In addition: All risks are RAG rated according to severity and likelihood; mitigating actions are monitored and reported. Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework. ~~The Trust Management Executive (EDs and CDs) is the designated risk management committee of the Trust and provides summary reports of its activity to the Trust Board.~~	Yes
For governance, that: 8. the necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	The Board and its sub-committees are involved in the development of the Trust's annual plans, including specific aspects as required (financial, winter pressures, infection control, health and safety etc.). Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework. The Audit and Governance Committee, like all Board committees, provides a report to the Board following each meeting which is presented by the Committee Chair (a NED). The Board is fully engaged with ~~to~~ the development of the IBP and the Clinical Strategy that underpins it.	Yes
For governance, that: 9. an Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	The Annual Governance Statement 2013/14 was agreed by the Trust Board in May 2014. The guidance for the 2014/15 Governance Statement has now been issued, and ~~is being reviewed by the Trust Secretary. The Statement will be prepared by the required deadlines.~~ and the 2014/15 Statement has been agreed by the Trust Management Executive. It will be submitted to the NHS TDA (and the Trust's auditors) by the required deadline of 23rd April 2014	Yes
For governance, that: 10. the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	Quality and governance indicators are monitored by the Board each month through the integrated performance dashboard. The Board is committed to achieving all targets and has set the vision of being in the best 20% of acute trusts nationally. Although the Trust ~~is now unable to~~ did not meet the required performance (95%) in terms of the A&E 4 hour waiting time target	Yes

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	for the 2014/15 year, the Board confirmed (in February 2015) that a compliance status of "Yes" was appropriate for the statement, on the basis that the Trust's plans were sufficient to deliver the 4-hour A&E waiting time target, even though the target would not actually be met.	
For governance, that: 11. the trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit	The Trust has achieved IG toolkit level 2 for ~~2013/14, and the proposed year-end submission for~~ 2014/15 ~~maintains Level 2 achievement~~ against all Requirements. The submission was approved by the Trust Board in March 2015	Compliant
For governance, that: 12. the board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	A Trust Board Code of Conduct is in place which confirms the requirement to comply with the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. A register of Directors' interests is maintained and Board members are invited to declare any interests relevant to the agenda at the beginning of each Board meeting, and each Board sub-committee. The Register of Directors' Interests was refreshed in March/April 2015. A new Non-Executive Director commenced in September 2014, which means that all formal Board positions are now filled substantively.	Compliant
For governance, that: 13. the board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	~~▪ The composition and operation of the Board has been debated in Board development activity and a paper produced to enable the further review of Board composition when vacancies occur.~~ ▪ A launch session for the Board development programme for 2014 took place in December 2013, facilitated by Hay Group; this will synchronise with separate Executive Director, Clinical Director, General Manager/Matron development programmes. ▪ The Remuneration Committee reviews the performance of Executive Directors. ▪ The TDA has conducted a review of the Trust Board. ▪ The Trust continues to adhere to the Oversight process ▪ A proposed approach to the new 'fit and proper persons' Regulations was approved at the December 2014 Trust Board, and implementation has commenced (DBS checks are currently	Compliant

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	being processed for all Board members).	
For governance, that: 14. the board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan	▪ All Executive Director (and Clinical Director) positions are filled. ▪ The objectives of Executive Directors cascade from the Trust's corporate objectives which are agreed by the Trust Board. The Trust Board agreed the Trust's objectives for 2014/15 in September 2014, and agreed that these objectives should also apply for the 2015/16 year (subject to minor amendments regarding specific targets)	Compliant